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ABSTRACT

Prepared by the National Council for Homemaker Services for those concerned with homemaker programs, this document contains selected papers which summarize the developments of the homemaker-home health aide service. Sections are: (1) The Philosophy and Goals of Homemaker-Home Health Aide Service, with papers by Elizabeth G. Watkins and Ellen Winston, (2) The Various Patterns of Homemaker-Home Health Aide Service, with papers by Maud Morlock, Nora P. Johnson, Louise Foresman, Johnnie U. Williams, Georgia P. Hughes, Rose Brodsky, C. Knight Aldrich, and Brahna Trager, (3) Standards for Homemaker-Home Health Aide Service, (4) Administering and Financing Homemaker-Home Health Aide Service Programs, with papers by S.A. Mandalfino, John W. Cashman, and Ellen Winston, (5) The Development of Homemaker-Home Health Aide Staff, with papers by Elizabeth Burford, Brahna Trager, Catherine Williams, Johnnie U. Williams, and Ione Carey, and (6) Home Help Services in Other Countries, with papers by Elizabeth Carnegy-Arbuthnott, Margareta Nordstrom, and Carmen Jonas. Selected references and the 1966 survey report are appended. (SB)

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READINGS IN HOMEMAKER SERVICE

Selected Papers Presenting the Background, Uses and Practices of Homemaker-Home Health Aide Programs

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NATIONAL COUNCIL FOR HOMEMAKER SERVICES
1740 Broadway • New York, New York 10019

Service Defined

Homemaker-home health aide service is an organized community program provided through a public or voluntary non-profit agency. Qualified persons — homemaker-home health aides — are employed, trained and supervised by the agency. They are assigned to help the chronically ill, disabled, and aged in their own homes, as well as families with children, who may require many different kinds of assistance with their daily living.

The service helps to protect and restore individual and family functioning. It serves to prevent the placement of children and adults away from their own homes. Often the homemaker-home health aide plays a large part in helping an individual who has experienced a physical, mental or emotional problem to reach an optimum goal in functioning. Of major importance in helping families is the homemaker-home health aide who assists the family members in improving their level of living.

The service should be available community-wide for individuals and families in all economic brackets when needed, for as long as it is needed.

NATIONAL COUNCIL FOR HOMEMAKER SERVICES, INC.
1969

President — MRS. ASHER YAGUDA
Executive Director — MRS. ROBERTA HUNT

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Foreword

READINGS IN HOMEMAKER SERVICE is the first volume of its kind to be published. Its appearance in the late 1960's marks the emergence of this essential type of community service from its slow beginnings to its present state of rapid expansion and development.

The National Council for Homemaker Services believes that many individuals concerned with the development of homemaker programs will find it helpful to have, in one readily available publication, material which summarizes the developments in homemaker-home health aide service in the United States from the early inception of this type of basic community service up to the present. The literature, in terms of published articles and papers and more fleeting unpublished materials, has been carefully reviewed to select major contributions for inclusion. Other significant papers which could not be included in a relatively brief volume are noted in the extensive bibliography.

In preparing this book of readings, the National Council for Homemaker Services had the assistance of an Advisory Committee representing health and welfare agencies with special knowledge and concern for homemaker service and the field of social work education.

The National Council for Homemaker Services is grateful to the Lois and Samuel Silberman Fund for its generous grant which made possible the compilation of this volume. The National Council is indebted to the Edwin Gould Foundation for Children and an anonymous donor for sharing in the costs of printing. It also is most appreciative of the cooperation of the agencies, publishers, and authors who have given permission for the reproduction of the various materials. The Council gratefully acknowledges the contributions of the members of the Advisory Committee who assisted in producing this important volume.

Betty Trippe

MRS. JUAN T. TRIPPE, *President* (1963-68)
National Council for Homemaker Services

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Introduction

Homemaker service* is one of the truly important services developed in recent decades. It has an increasingly more significant mission as our society becomes ever more mobile, more industrialized, more automated. In a very real sense it provides the connecting web between the family and the other services the family requires from the community, whether on a short-term basis or for extended periods of support.

As society recognizes more fully the importance of public and voluntary provision of those constructive programs which facilitate strengthened family living and inter-relationships with the community, homemaker service will develop apace. Fortunately, it is not a difficult service to render. Nor is it expensive in relation to the alternatives which would be necessary without its availability.

This is one of the services which may become essential to the well-being of almost any family at some time in its life cycle. Therefore, it is not limited to any single economic group or social group of beneficiaries.

Homemaker service is designed to meet a broad range of individual and family needs in time of crisis or where illness and disability are involved. Perhaps even more important, it helps families to upgrade the level of living and improve home conditions and child care practices where poverty, ignorance and lack of opportunity have prevented them from acquiring the kinds of knowledge and skill needed to maintain a wholesome, healthful, orderly home environment and to provide adequate care for children.

More and more this service is recognized as being of major importance to women, since the responsibility for the maintenance of the home and the daily care of young children, the aged, the chronically ill and disabled falls most heavily upon them. With the growing demand for women workers, including women heads of low-income households, there must be corresponding recognition that in-home services need to be provided to assist them in meeting the demands of regular employment. This may involve a few hours a week or full time at special points, such as during illness of their children. Moreover, there is increasing pressure to help the aged and chronically ill remain in their own homes, due to the growing knowledge that many older and chronically ill people fare better there than in other environments. Also, the pressure to keep people out of high cost hospitals, nursing homes and other institutions intensifies the need for homemaker service. This involves assistance to families in maintaining the home, as well as, in some instances, providing personal care for such persons. Homemaker service is highly flexible in respect to the kinds of situations it can meet, the hours of service, and the utilization of manpower to make maximum use of the homemakers employed in serving individuals and families.

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*Three terms are in general use: homemaker, home health aide, and homemaker-home health aide. In this report the generic term homemaker is generally used for the service in varying settings and under various auspices, although the other terms are also used in the materials from other sources which are included here.

While homemaker service may be needed by families, regardless of economic status, the need is greatest in the groups with the lowest incomes. Using the gauge of need for low-income families of one homemaker per 100 families and one per 100 aged and disabled individuals (the best estimates available from experience in the field), we would need in this country 50,000 homemakers for low-income families (estimated at 5 million) and another 80,000 for the lowest-income groups of aged and disabled (roughly 8 million persons). If the need for service for all income groups is to be met, another 70,000 to 80,000 homemakers would probably be required. Although the priority need is for low-income families and the aged, certainly long-range planning should take into account the needs of the total population for homemaker service.

Federal Legislation Expands Financial Resources

Financial resources for the public assistance categories and other similar low-income groups have been expanded through recent Federal legislation. Seventy-five per cent Federal financial participation is available to states that establish and operate homemaker programs for public assistance recipients. Moreover, funds from the Children's Bureau are available to assist in developing such programs for serving children.

Under Titles XVIII and XIX of the Social Security Act, persons receiving medical care may have homemaker-home health aide service purchased for them, with payment from Medicare and medical assistance. Since home health aide service may be purchased only in connection with an active medical treatment program requiring services in the home, it is often necessary to discontinue the service because there is no resource for payment when the active medical treatment program under either Medicare or medical assistance is discontinued or when the person's entitlement is exhausted. For many such cases it should be possible to continue homemaker service as long as needed under public welfare auspices. Public Health Service and Office of Economic Opportunity funds have been made available to some local communities and to some states for development of homemaker-home health aide projects, although these agencies are not able to fund the programs on a continuing basis.

Recruitment resources for homemakers are almost unlimited. There is a vast pool of women with an education of high school level or less, between the ages of 20 and 65, who would be capable of and interested in becoming homemakers. Home economists, social workers and nurses are potential sources of recruitment for supervisors and directors of this service. Schools of social work and other institutions offer resources for short-term training for homemaker staff. The U.S. Department of Health, Education and Welfare and the National Council for Homemaker Services provide consultation and special workshops for directors and supervisors of homemaker services.

Service Meets Broad Range of Needs

The greatest problem to be overcome is the fragmentation in the field. This results partly from fragmented resources for financing, partly from the details of Federal law, and partly from the various goals of the field. Some groups see the service as primarily meeting health needs; others see it primarily as a child care program or for meeting emergency situations in the home; still others see it as a basic program for helping to raise levels of living and to strengthen family life. There needs to be clearer and more widespread understanding of the fact that this service can meet a broad gamut of needs that may arise in any family, often involving both social problems and health care simultaneously.

Dynamic leadership can help every community and each state understand this service for what it is and assure its rapid growth on a sound and unified basis. The first order of business should be to develop sufficient numbers of programs with adequate numbers of homemakers to meet the need for good service in every community for all low-income groups, with expansion as rapid as possible to other income groups. The service needs to be easily accessible, without arbitrary and cumbersome eligibility or other requirements. It needs to be provided under agency auspices accountable to the community, to the employed homemakers, and to the families served, for quantity, quality and cost of service. Ultimately, enough homemakers should be available (estimated at over 200,000 homemakers deployed throughout the United States) to provide service, as needed, for the entire population.

Homemaker service in its most effective forms is a constructive program, developed by society to fill gaps in a broad spectrum of other social and health services in the community. An affluent society can afford to meet the needs with which homemaker service is designed to cope. Indeed, it cannot afford to provide inadequate or fragmented services so directly related to constructive approaches to family life.

Foretelling the future is always risky. Looking at past records, however, and present needs, and with many relatively clear indications of what our society will be like in the future, it seems relatively safe to predict that homemaker service will have phenomenal growth in the years immediately ahead. By 1975 it should have become part of the warp and woof of comprehensive social and health services in every part of the nation.

Section I

The Philosophy and Goals of Homemaker-Home Health Aide Service

Statements concerning the philosophy and goals of homemaker-home health aide service appear in one form or another in a number of the selections contained in this volume as well as in the Introduction to the total collection. In the present section, three papers are presented which are particularly relevant to an understanding of the service's objectives and values.

Given the nature and reality of our present industrial urban pattern of living, homemaker service is a necessary community resource which should be available when a particular family or individual needs to utilize it, in somewhat the same way that educational resources are needed by all but utilized most extensively at certain phases of the life cycle. Homemaker-home health aide service is moving from a service available to the few to help cope with specific crises, to a societal provision designed to promote the continued well-being of many members of our society in both urban and rural areas.

Homemaker Service in the United States*

by Elizabeth G. Watkins
Staff Associate
American Public Welfare Association

Before presenting the background of homemaker service in the United States, it would be helpful to recall some of the mores and values of our society which have affected the development of homemaker service in this country. In the early decades of this nation, our pioneer families did not possess the same family ties that they and their ancestors had known in Europe. Small segments of large families and single individuals were the early migrants to the United States, although the usual pattern was for other members of the family — wives and small children, older parents and other close relatives — to be sent for as soon as the newcomer had settled down in a community and in a job.

Great value was placed upon independence and self-reliance in the individual, with inter-dependence among neighbors a characteristic of mutual helping methods of meeting catastrophic events. As our society evolved from a pioneering one of exploration and settlement into a stable agrarian order and then into industrial urbanism, each phase steadily increasing our national affluence, we paid increasing homage to the virtues of independence, self-sufficiency and material achievement.

Based, in part, upon our European legal and cultural heritage and molded by our environment, our economic, political and social structures, certain forces and public attitudes have determined the nature of social welfare philosophy, programs, and practices in the United States. Among those which have significantly influenced the development of homemaker service are: the extended era of institutional programs for various types of dependent persons; the centuries-old acceptance of the premise that the "poor are always with us," with the concomitant acceptance of acts of charity as religious and moral obligations; the prevalence of the assumption that poverty inevitably was associated with laziness, lack of initiative and a variety of undesirable personal, cultural and ethnic attributes; the widespread assumption, even in contemporary times, that social services are for the poor, the under-privileged, the deprived in our society; the fears and concerns of citizens over the danger of "coddling the poor," which is an euphemism to justify restrictive regulations and inadequate grants in public assistance programs; the depression of the 30's; and the development of governmental welfare programs under the Social Security Act of the mid-30's and the

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**Paper given at the International Conference of Social Work in Washington, D. C., August 30, 1966.*

subsequent amendments thereto.

In the decades prior to World War I, two voluntary family welfare agencies employed visiting housekeepers to work with families whose need was based on the illness and consequent inability of the mother to take care of home and children. The names of the agencies indicate the status of the families to whom help was given; i.e., The Family Service Bureau of the Association for the Improvement of the Conditions of the Poor, in New York City; and the Associated Charities of Detroit, Michigan. A few years after World War I (1923), the first organized homemaker program in the United States was initiated by the Jewish Welfare Society of Philadelphia, Pennsylvania to place motherly women as housekeepers in homes where the mothers were temporarily incapacitated, in order to avoid the placement of children in institutions and foster homes.

During the 20's and early 30's, a gradual increase in homemaker programs occurred in the voluntary family and children's agencies.

First Goal—to Prevent Uprooting of Children

The primary purpose of these early programs was to prevent foster home or institutional placement of children because of the incapacity or absence from the home of the mother. The depression years of the 30's saw the development of programs of housekeeping aides under a Federal program of the Works Progress Administration. Although the primary purpose of the Housekeeper Aide projects was to train and provide employment for needy women, the health and welfare agencies to whom these women were assigned made effective use of their training and skills to provide services for families with children, disabled or chronically ill, aged persons in their homes.

During the 40's and 50's, there was a slow but steady increase in homemaker service programs, with the greater increase in voluntary family and child welfare agencies. It is particularly important to note the sustained efforts of a small voluntary group, the National Committee on Homemaker Service, which was the immediate outgrowth of an informal conference convened by a Federal agency, the U.S. Children's Bureau, with participation by representatives of voluntary and public welfare and health agencies throughout the country. Members serving on the National Committee on Homemaker Service were representative of the helping professions, governmental and voluntary, national and local organizations, agencies and lay boards. The dedication and determination of this small group was undoubtedly the single most consistently sustaining force in actively promoting and encouraging the development of homemaker programs in a variety of agencies. The composition of this committee indicates the kind of coordinated effort and activity among voluntary and governmental organizations which continues to be an important characteristic of the homemaker field in the United States.

At the level of the Federal Government, funds to provide substantial support for homemaker programs are available through grants to the states by the Department of Health, Education and Welfare, Welfare Administration, Bureau of Family Services, Children's Bureau, through several programs under the United States Public Health Service, the Vocational Rehabilitation Administration.

Training programs are available through the Office of Education and the Manpower Development and Training Programs of the Department of Labor. State and local governmental units also provide funds for these services in state-wide or local programs. In addition to funding the homemaker programs, the Federal or state agencies provide consultation and assistance to both public and voluntary agencies.

Homemaker programs in the voluntary field have continued to increase in family and child welfare agencies, in community nursing and health services, and in independent homemaker agencies. Wherever the new programs are established, or older programs expanded, there are planning or advisory groups which represent a cross section of the community. Questions and decisions on auspices, financing, purpose, structure and administration involve lay and professional persons who are identified with community services, needs and resources.

On June 30, 1966, a total of 545 agencies in the United States and Canada were providing homemaker service. Of this number, 492 were in the United States; 227 were public agencies, 256 were under voluntary auspices and nine were combined public and voluntary endeavors. These 492 programs are located in a wide variety of agencies. In the voluntary field, the largest number of homemaker service programs are in family and child welfare agencies, with independent homemaker agencies constituting the second largest group. Smaller numbers are located in visiting nurse associations and other health agencies. In the public field, by far the greatest number are in state and county welfare departments, with a relatively small number in health or other public agencies.

Great Variety of Auspices Noted

Despite the high percentage of programs in certain types of agencies, it is interesting to note the range and variety of other auspices which include: a state hospital for the mentally ill; maternal and infant care projects under local boards of health; a special health project sponsored by the United Cerebral Palsy Association; a program under a local school Public Adjustment Program; and several hospital and clinic home care programs.

The geographic distribution of homemaker service is also wide. In the early years, services were concentrated in highly urban areas of the country. With the increase in services, there has been a wider distribution. The comparative growth is more rapid in the public field where most programs offer county-wide services, although some are on regional or state-wide bases.

Another significant change in recent years has been the trend toward more flexible and inclusive service. Few, if any, agencies have rigid time limitations of service, either in terms of duration or the daily hours involved. The duration of the service is determined by the continuing need for it which, in turn, is determined by the continuing assessment by the professional worker, or team, and the family. This joint assessment also determines whether or not service is provided four, eight or 24 hours a day, the number of days a week, the nature of the service, and any modifications required by changing circumstances.

Service Used in New, Exciting Ways

Homemaker services, while expanding in the traditional areas of use, i.e., to provide care for children in their own homes and to assist and enable ill, disabled or aged persons to maintain themselves in their own homes, also are used in many new and exciting ways. In general, homemaker service augments and extends the wide range of social welfare and health services designed to maintain, improve or support the social and physical functioning of families and individuals in their homes and communities. In some communities homemaker service is provided for migrant farm labor families who move from state to state during the harvest season.

Homemakers are used in protective services, in teaching immature and inadequate mothers how to care for children and manage their homes. In some instances homemakers assist in group sessions for homemaking and child care training activities for adolescent mothers, in rehabilitative work with the disabled in post-hospital care, and special projects with families of severely retarded or emotionally disturbed children. They may be assigned for 24 hours a day in single-parent homes where the mother is hospitalized, or they may be assigned for two or three hours daily or at intervals throughout the week to meet the needs of a solitary elderly householder. A homemaker may remain in the home a few days or for an indefinite period, according to the specific needs of the family.

Great impetus to the broadening scope of homemaker services was given by the enactment of Title XIX of the Social Security Act, which made support available for a wide range of health programs, including homemaker-home health aide service and other in-home services. Still broader availability and utilization of these services are in the provisions of Title XVIII, more commonly known as the Medicare Act.

Under these major national health programs, specific coverage is provided for home health aides. The title is essentially descriptive of the function, and is not indicative of differences in the qualifications of the personnel. The similarities between homemakers and home health aides are clearly stated in the following excerpt from a statement issued by the Bureau of Family

Services, Department of Health, Education, and Welfare:

> ". . . personal care for the ill or disabled may be provided by homemakers and/or home health aides, provided proper standards and safeguards are maintained. These services are alike in the following ways:
>
> a. They enable ill or disabled persons to return to or remain in their own homes.
> b. They are carried out by mature women (sometimes men as home health aides) whose background and experience indicate their capacity to provide the needed personal care.
> c. The helpers are recruited, trained, assigned, and supervised by the professional staff of the agency which employs them.
> d. They are part of a total service program, either health or social welfare or both. In other words, neither the homemaker nor the home health aide provides services alone but always as a part of a team effort, and under professional supervision."

The significant difference is:

> "The home health aide is used when there is a specific need for personal care and attendant-type service for an ill or disabled individual. It is a specific service and limited to persons under an active medical treatment plan."

Service Will Continue to Grow

With the Medicare program reaching approximately 19 million persons, 65 years of age and over, and the recognition in geriatric practice of the importance of home-care health programs for the aged, we may be certain that the expansion of homemaker-home health aide programs in the United States is still in the early stages.

Any rapidly expanding service seems to develop complexity in geometric progression and with its multiple sources of funds, the range of sponsorship and auspices, the intricate combinations of administrative, training and supervisory functions among agencies, homemaker-home health aide service may well run the gamut of inter-agency and inter-disciplinary complications. This could be an overwhelming thought, but it is not because there are balancing factors on the other side of the ledger. The pattern of cooperative, coordinated planning is well established. Cohesiveness, which was nurtured by the National Committee on Homemaker Service, has characterized the field throughout its initial developmental stages. The young, vigorous and vitally important National Council for Homemaker Services is representative of the spirit and process of cohesion and coordination. Implicit and explicit in its role, function and its relationships with its members and the field of homemaker-home health aide service are its responsibility for leadership in promotion, standard setting, interpretation, education and the essential coordination of the many and varied strands that constitute the fabric of our homemaker programs in the United States.

Homemaker Service and Social Welfare*

by Ellen Winston
U.S. Commissioner of Welfare
Department of Health, Education, and Welfare

It is a real pleasure to be among so many people from so many parts of the world who share our keen interest in the development and expansion of homemaker service programs. The growing interest in these programs is, I believe, a reflection of the increasing recognition in all countries of the need for and value of broad social welfare services.

Social and economic developments around the world have led to many changes in our way of living. While many of these changes have been good, resulting in a better life for most people, they have also created problems and left some people stranded between the old and the new, bereft of many of the advantages of either. Progress exacts a price: in the disruption of accustomed patterns of living which puts new strains upon family life and adds to the problem of divorce and family breakdown; in demands for different work skills which create unemployment among the under-skilled and under-educated; in changing social values; in new roles for women, with a trend toward more and more of them working outside of their homes; in the rising birth rates and lowered death rates which mean that we have more people at a time when automation and other labor-saving devices are performing many of the tasks that formerly required human labor.

To cope with the human effects of these rapid social and economic changes, it has become necessary for all countries to develop a broad range of social welfare services. And we are becoming more precise in the development of such services; both the content and the methods of helping people are becoming increasingly exact.

For example, it is now apparent that we need to expand social welfare services in two general directions: in the building up of community facilities, such as day care centers for children, activity centers for the aged, and other programs that serve groups of people; and in the strengthening of counseling, casework, and other services for individuals or family units.

There is, of course, no clear-cut dividing line between these two types of social welfare activities. The clientele of centers, clinics, and other facilities frequently require and—at least in the best of such facilities—receive counseling and other help on their individual problems, from personnel with competencies similar to those whose work more typically involves a one-to-one relationship with their clients. Both approaches are essential in reversing the

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Paper given at International Congress of Homehelp Services at Koenigstein, Federal Republic of Germany, September 8, 1965.

trend toward depersonalization which is so often the unwanted by-product of an urbanized, industrialized economy.

No country, I believe, can claim today that it has yet achieved social welfare programs of both group and individualized services which give all its people ready access to the kind of human and personal help that all of us need from time to time. That is why it is so important that we share with each other what we are learning as we try to provide a broad range of social services. And since homemaker services are very definitely among the services that must be included as a basic part of any broad-gauged social welfare program, I think one of the important ways in which we can help each other is through exchange visits with persons operating homemaker services in other countries.

In the United States, we do not as yet have any formal arrangement for such exchange, although many of our citizens have visited your countries and studied your programs. Some of your countries, I believe, are ahead of us in this respect in that you do have an established system for exchange of personnel. In fact one of our voluntary agencies now has its fourth "interne" placement from another country. The director of that agency recently wrote to us about this placement and this is an excerpt from her letter: "We are enjoying our interne and she appears to be enjoying us, too, and needless to say, we are teaching one another. We are astonished at the way they manage volume. She was impressed by the way we try to get quality services."

Interneships Are Recommended

Many of us believe that some kind of interneship, including attendance at conferences and meetings and short-term institutes, could offer much; and I hope this Council will include such arrangements in its future plans.

At the National Conference on Homemaker Services which the United States held last year, we were privileged to have three guests from Great Britain. Miss E. Carnegy-Arbuthnott, the President of the International Council, gave one of the major addresses at this conference and the people in the United States found this a most stimulating, as well as a most enjoyable, part of the conference.

Next year the International Conference on Social Work will meet in Washington, and we hope it will be possible for many of you to attend. We expect to have some sessions on homemaker service because this subject is of increasing interest to social workers as they recognize the important role the homemaker can play as a member of the social welfare team.

This recognition has come about as it has become more and more apparent that there are many additional functions for homemaker service—over and beyond the care of people when they are ill, of small children when they need it, and of the frail aged.

How the Homemaker Helps

In our country, one of the most important functions of a homemaker today is to work with deprived families in an effort to help them raise their level of living. Homemaker service is a simple, economical, and flexible service that offers an immediate way of help and hope to people. It enables them to make the most of whatever resources are available, not only in the management of their money, but in many aspects of their daily lives. The homemaker extends and augments services provided by other community agencies. She does this by demonstration, as well as by helping with the care of children, the maintenance of the home, and other activities of daily living.

It is important that we examine carefully the kind of living patterns we want to help these families to change. In most instances, the families seeking help with problems of daily living are what we call "multi-problem families." They have limited financial resources, or may be without any income at all except from public assistance. Often they lack the basic necessities, such as sheets for the beds, an adequate stove to cook on, and refrigeration. Others have chronically ill or disabled persons in the home. Sometimes the illness is physical, sometimes it is mental; and often it is both. Problems may include total family disorganization, or disruptive behavior on the part of adults or children, or both. We believe there is no single service which offers greater potential than homemaker service for helping such situations—especially when such service is provided in coordination with a broad range of other community services, both social and medical. Homemaker services are concerned with the welfare of the individual in his own environment, and consequently they must be geared toward dealing with the quality of the environment as well as with the personal needs of the individual and his family.

In this connection, I would like to summarize and paraphrase a few paragraphs from a paper given by Brahna Trager, Director of the San Francisco Homemaker Service Agency, at the Minnesota State Welfare Conference earlier this year, because it so well expresses the needs and values of this aspect of homemaker service. Miss Trager writes:

"We have seen homemakers raise motherless children and do a wonderful job of it. We have seen homemakers help with a massively handicapped child, a mentally retarded child, and a mentally disturbed mother with little children, in ways that are so infinitely understanding and compassionate that perhaps no other kind of person could have achieved so much. We have seen homemakers work with mentally confused elderly women, and reduce that confusion to the point where the physician changes the diagnosis of senility—because there has been re-integration of the person in her familiar situation. We have seen homemakers provide eyes and ears for the social worker, the psychiatrist, the physician and nurse, with a kind of carefulness of observation and continuity that can never be achieved through single home visits, office consultations, or even in the institutional setting.

"It has been said that 'family life at its best is an enabling thing—it enables people to do what Freud once said were the most important things: to work and to love.' But neither the creativity necessary for the one nor the awareness necessary for the other are well nurtured in poverty, despair, and disintegration. It is certainly true that our institutions cannot eliminate all of the horrors that are a part of the human condition, but it does seem that we are still far behind in making the kind of courageous new approaches to the organization of our social institutions which could do a great deal to mitigate them. Homemaker service, at its best, can be a strong link in a chain of related sustaining and protective services."

Juvenile Delinquency Is Her Concern, Too

Miss Trager did not specifically mention the role of the homemaker in relation to the growing problem of juvenile delinquency, but I think it is worth special mention because juvenile delinquency is one of the manifestations of the social disorganization of our times. The acting-out of children and teenagers often becomes such a problem to parents, schools, and community leaders that they become immobilized in dealing with the delinquent. In such situations, it has often proved extremely helpful to have a homemaker assigned to the home. She can help relieve pressures on the parents and children and provide the kind of on-the-spot observant advice and counsel that both parents and children need. With the guidance and assistance of the social work staff, both the homemaker and the family find themselves better able to cope with the underlying problems, and to relieve the distress which has led to the child's undesirable behavior.

Obviously, in such situations, as in the situations so graphically described by Miss Trager, the homemaker cannot assume sole responsibility. She is, in a very real sense, a member of a team, supported in her efforts by a social worker and by a whole complex of services and facilities in the community. Even so, in this type of work, the homemaker needs considerably more imagination, initiative, and understanding about ways of motivating people than would be required of a person whose only duties relate to housekeeping tasks.

Another less traditional use of homemaker service that is now developing rapidly involves working with groups of disadvantaged mothers, providing a kind of group teaching and demonstration program which enables these mothers to make better use of their limited resources. This calls for leadership and for the ability to carry the group along, keeping them interested and highly motivated.

Homemaker Service Defined

In the United States, homemaker service is defined as "a community service sponsored by a public or voluntary health or welfare agency that employs personnel to furnish home help services to families with children; to convalescent, aged, acutely or chronically ill, and disabled persons; or to all of these." Its primary function is the maintenance of household routine and the preservation or creation of wholesome family living in times of stress. Because homemaker service should be offered on the basis of a social diagnosis and often on medical diagnosis as well, trained professional persons should evaluate the type of service needed and the length of time it should be given.

This definition points out that homemaker service is not a self-contained service, unrelated to other needs of the family. It suggests certain essential elements which, we believe, must be a part of a quality program. Let us take a closer look at what these elements are:

First, homemaker service is an organized community program.

Second, the service is sponsored by a health or welfare agency as an integral part of its total service.

Third, homemakers are employees of the sponsoring agency, which is responsible for their training, supervision, and overall performance.

Fourth, the homemaker's assignment in a home is based upon a professional evaluation and a service plan which provides for other social and/or medical needs in the family situation.

Homemaker Is Member of Team

It should be clear, then, that the homemaker's work, important as it may be, is not performed in isolation. It is performed in concert with other specialized professional social and/or medical services which the family situation may require. Thus, the homemaker is a member—a vitally important one—of the social welfare team. In our country we say that she provides, in addition to willing hands, another set of eyes and ears to aid social workers, doctors, nurses, psychologists, and others in better understanding family functioning and in dealing more precisely with problems within the framework of their professional competencies.

Most often, the homemaker is part of a team which also includes a social caseworker. Perhaps an illustration will show how this team relationship works.

The caseworker for a family which received financial assistance from a public welfare agency, in one of our southwestern states, became particularly concerned about 4-year-old Tommy. Tommy's mother was 27 years old, widowed by a tragic accident, limited educationally and inexperienced as a mother. She had three other children in addition to Tommy: a 5-year-old, and 2½-year-old twins born just prior to her husband's death.

The caseworker discussed her concerns for Tommy with his mother. The boy seemed almost too quiet, he looked undernourished, seldom smiled, and was never playing with other children when the caseworker visited the family at home.

The mother was surprised at these observations. Of course, Tommy was quiet, but at least she wasn't harassed by him as by the others who demanded so much of her attention. His appetite was good, but he soiled his pants too often for a boy his age. The last time he did that, she had tied him to the toilet seat for a few hours to impress upon him her displeasure and she thought he would not do that again. "Maybe," she went on to the caseworker, "you think I'm too hard on Tommy, but there's so much to do, being both father and mother . . . I do the best I can."

The caseworker assured the mother that she realized what difficult responsibilities the mother faced and told her about the agency's homemaker program. Would she be willing to have a homemaker assigned to help with the care of the children and household chores? Perhaps she could learn some "short-cuts" from the homemaker. And, perhaps the homemaker's observations of Tommy would aid both mother and the caseworker to learn more about Tommy and how he could be helped to grow.

The mother agreed to the plan and a homemaker was assigned to the home. She was a grandmotherly person but flexible enough to offer her teaching by example, not exhortation.

Homemaker's Observations Determine Service

The homemaker soon learned that Tommy was an ignored, if not frankly rejected, child. He had never been given solid food and, therefore, did not know how to chew. His quietness seemed to be the result of almost no vocabulary. And because he demanded no special attention, he was given none except when he soiled himself.

The homemaker set about to teach this young mother how to mother Tommy. Often as she worked, she asked Tommy to "help" her. When they did the dishes, she identified objects for him, repeating over and over: "cup," "spoon," "dish." She set aside some time that was exclusively his. During these times she read to him, again identifying objects and colors, and encouraging him to repeat words after her. The homemaker sang to Tommy and played games with him.

In the beginning, the mother merely watched the homemaker and Tommy, busying herself with other tasks or taking some much needed rest. But she was learning, seeing what this child needed and noting his response. After a short time, when Tommy's "special" time came, the homemaker encouraged the mother to spend it with him while she (the homemaker) looked after the other children and the home.

A change in Tommy and in the whole family soon became evident. They were enjoying family life. Home had become a happy place, where love and attention were freely given, not merely "on demand." Tommy's vocabulary began to develop, he began eating solids and enjoying them.

His little body began to fill out and he was becoming a real boy!

Throughout the homemaker's work with this family she kept in touch with the caseworker, sharing her observations of progress and problems. The caseworker helped this mother to arrange to purchase a second-hand washing machine in good condition, to secure rubber sheets, and additional clothing for the children since lack of these things contributed to the drudgery of maintaining the home. The caseworker arranged for a medical evaluation of all the children and received specific recommendations for Tommy's diet to enable him to "catch up" in his development. These recommendations were discussed with the mother and the homemaker to make sure they were understood and carried out.

Here we have seen the team at work. The caseworker evaluated the problem and determined what additional help was needed—in this instance, homemaker service. She explained the purpose of the service and prepared the family for it. She participated in selection of the "right" homemaker for this family, explained the family's needs and the goals of the service. And throughout the homemaker's assignment, the caseworker kept in close touch with the family situation and saw to it that the family and the homemaker received other services (medical) and assistance (household equipment) necessary to support the goals of homemaker service.

Caseworker's Support Is Essential

Over and over, experience has shown us the importance of the caseworker's support in homemaker service. We are encouraging, in our country, the use of homemakers to help families raise their levels of living. We have seen how well the homemaker fills an enabling role—a catalyst who stimulates families to make better use of what limited means they have, who helps them to find and to use the legal, social, and economic resources offered by their community.

Recently we heard of a family of children who ran to the table and seated themselves whenever the homemaker arrived. She had given them their first experience in what a family meal means. She symbolized food and warmth and love. The poignancy of this story touches us; yet we are acutely aware that the homemaker alone could not have accomplished this. Such results are due to collaborative efforts in the family's behalf between the homemaker and caseworker.

Usually, situations such as the one I have described come first to the attention of social agencies. Communities look to social agencies to intervene and take remedial action when children fail to receive the care they need due to a range of problems in parental functioning. Thus, it is the social worker who first receives a community complaint or is otherwise referred to a family or individual situation in which homemaker service or other service is needed.

Recognizing that planning with and in behalf of a family must be based on knowledge of certain facts about them, the social worker's first task is to assess both causes and effects of the problem and the capacity of the family, individually or as a group, to cope with their difficulties. (Many social workers have found that assignment of a homemaker is an aid in helping them better understand family interaction.) Armed with this knowledge, the social worker then is able to make decisions about what resources, aside from her own services, seem best suited to the family's need. With their participation she proceeds to secure, and to help the family use, agency or community resources.

Whatever resource is available to help, the social worker has a role to play in enabling the family to use it in such a way as to bring maximum results. When the resource is homemaker service, she must help both the family and the homemaker to understand the goals of the service. She must see to it that the home has proper supplies and equipment to enable the homemaker to work. She must see to it that there is adequate food and clothing. She must be sure that medical care is made available if needed. She must determine how long a homemaker is needed and what changes in the family indicate termination or re-focus of the homemaker's work. This kind of help from the caseworker, in coordination with the homemaker's work, is what makes possible achievement of the desired results of homemaker service, particularly with low-income families.

And I want to emphasize that planning is done *with* the family to the extent of its capacities, since the role of the social worker is not to take over people's lives but to provide, when needed, the supports which enable them to cope more effectively with their own problems and needs. We say in our country, she "helps them to help themselves."

It should be quite clear, and I want to avoid any misunderstanding, particularly in respect to using homemaker service to help raise levels of living, that the homemaker does not increase dependency by taking over the responsibilities of parents or family members. She enables them to carry out their responsibilities more satisfactorily by providing for them an example which has usually not been available in their previous life experience. She is thus a "culture-bearer" who teaches, by demonstration, a variety of roles which society expects of adults—mother, friend, neighbor, and responsible citizen.

Homemakers Have Status

As the homemaker, in these and other ways, serves as a member of a team which may include representatives of a number of disciplines—caseworkers, nurses, therapists, nutritionists, and others—she must meet higher standards of skills and competence than ever before. Nevertheless, the basic qualifications for careers in homemaker service have not changed. Often we talk as if we are describing that paragon who can be all things to all people. This is not true and we must guard against making technical qualifications for homemakers so high as to eliminate those who can best carry this responsibility.

We need good, sensible women who know how to keep house, care for children, and impart skills to others just as they would teach their own children the arts of homemaking. We can find and interest these women if we make them full-fledged members of the team and use their skills and imagination to the best advantage in helping families. They must have all the status and privileges of other staff members.

There is a broad field for expansion of services. We have hardly begun in most countries to fill the need for homemaker service. Moreover, all around the world there are women seeking employment as never before. Many of them have skills in making homes for themselves and their families and in caring for children. These skills are available for disciplined use in social welfare settings.

Some of the women who have proved to be most successful in our homemaker programs in the United States are college graduates; on the other hand, some who are very good have been recruited among the mothers of impoverished families who are dependent on public assistance and who have had very little formal education.

Regardless of their background, homemakers in the United States have status; the jobs have prestige; and there are good reasons why this is so. For one thing, homemakers are members of the staffs of well-established agencies. They are employed in public welfare agencies, in health departments, and in a variety of voluntary agencies. The length of their work week, their retirement, and other benefits are commensurate with those of other staff members. They are a part of the agency and their jobs carry the same recognition and respect as those of the social worker or nurse.

The vastness of the need is one of the reasons I emphasize the importance of making homemaker positions attractive, in these and other ways, and of keeping the formal qualifications down to a minimum.

Service Is Growing

Our statistical picture underscores the need to draw in more recruits. At present, the gap between the number of homemakers needed and the number available is far wider in the United States than in many of the countries that you represent. There are now approximately 5,000 homemakers employed in 400 agencies in the United States and they serve a maximum of 12,000 homes at any given time. As recently as 1963, there were only about 3,000 homemakers in 300 agencies, serving a maximum of 9,550 homes. So you can see that there has been encouraging growth in recent years. But to meet our needs we should have at least 200,000 homemakers.

Thus, we have a long, long way to go, farther than many, perhaps most, of your countries.

But we are on our way. Strong impetus was given to the movement by the passage of public welfare amendments to the Social Security Act in 1962, which authorized Federal funds to be used to pay 75 per cent of the cost of operating homemaker services as part of our public assistance programs. This means that state and local governments now need to pay only 25 per cent of the cost. Moreover, families with marginal incomes, as well as families who are dependent upon public assistance, can be eligible for this free service. The aged and disabled are also eligible. Additional Federal support for homemaker programs is available for programs that serve children in all income groups. These grants are authorized under our Child Welfare program. But it remains for each state government to decide whether it wishes to use either or both of these Federal grant funds for homemaker programs. Most states provide some homemaker service, but in no state are there programs that serve all areas within the state and that take all types of cases.

Almost half of all the homemaker programs in the United States are now operated by departments of public welfare, reflecting the powerful incentive provided by the availability of Federal aid. A growing number, particularly those specializing in service to the ill, have been developed by public health departments since 1961 when some Federal public health grants were authorized for that purpose. Other programs are operated by voluntary welfare and health agencies. Whatever their auspices, most of these programs focus most of their services upon low-income groups. The demand for the service among all income groups is increasing, however, and one of the challenges now facing us is how to make homemaker services more widely available to those who can pay all or a good part of the cost of the service.

Summing up, while we in the United States are still encountering serious problems of organizing, financing, recruiting, and training, we believe we are on the threshold of tremendous growth and development of homemaker programs. Several developments lead me to this conclusion.

For one thing, in 1962, a National Council for Homemaker Services was established and incorporated, the outgrowth of an earlier National Committee on Homemaker Service. The Council has given additional impetus to the development of homemaker service by cooperating with other national health and welfare agencies, public and voluntary, and with state and local organizations in rallying lay and professional leadership and in promoting improvement in the quality of homemaker services.

Last year, the Council and the Welfare Administration co-sponsored the 1964 National Conference on Homemaker Services, which I referred to earlier. The conference brought together some 800 lay and professional leaders in the field to exchange ideas and experiences on all aspects of homemaker services. Following the conference, the Council embarked on the development of a Standards Code which sets forth guidelines for development of new programs and for the improvement of existing ones. The Code is the first to be addressed to all homemaker services, irrespective of auspices or groups served.

Even more recently, the Council, under contract from the U.S. Office of Education, has begun work in developing a training manual for homemakers. We believe this manual will greatly aid homemaker service agencies, as it will pull together, from many fields, knowledge which homemakers need in their work; such as, how to work within an agency setting, understanding social problems and other problems which result in need for homemaker service, understanding behavior and needs of individuals at differing stages of life and recognizing their reactions to stress, and understanding hygiene and health, home nursing, food preparation, household management, and other relevant subjects.

Human Values Given Priority

Turning now to recent developments on a broader front, of which our homemaker programs are just one part, I would like to point out that under President Johnson's leadership, our nation has awakened, as never before in times of prosperity, to the importance of social development as a component of economic development. We are discovering that material wealth does not necessarily or automatically raise the quality of life for all of our people, and that if we are truly to have a "Great Society," we must pay far more attention to the intangibles, to the personal services, and to the human values that make life meaningful. Thus we find that more and more citizens are becoming involved in community planning. They are looking to social work leadership to assure that the plans give top priority to the welfare of people, and particularly to those people who have shared the least in our general affluence. Communities are being assessed in terms of the adequacy of their resources for health, for education, and for welfare; and new action programs are getting under way.

Social development, in brief, is a vital force in the United States as we recognize that our future economic progress, as well as the health, happiness, and general stability of our people depend upon it. And because homemaker services are an essential ingredient of a sound program of social development, I am confident that when we meet with you again, we will be able to report very substantial progress toward our ultimate goal of having a homemaker available to every family and individual who can benefit from her service. The experiences which you share so generously with us at these international conferences are of immeasurable value to us in this effort and I think you know, without my saying so, that if we can be of any help to you in the furtherance of your programs, we will welcome the opportunity.

Homemaker programs are a good example of a movement in which we can all share, no matter how varied our customs or mores, for the problems they deal with are the universal problems of the human race. In this year, which will be widely observed throughout the United States as International Cooperation Year, I take particular pleasure in having the opportunity to participate in this conference which is such a shining example of international cooperation in action.

Toward the Greater Benefit[*]

> "In our modern world, a world of clicking computers, changing organizational patterns, and data processing, it is all too easy to lose sight of simple values and needs. One of these we have discussed during these meetings is intelligent neighborliness. Priority should go, must go, to the most important organization or business in our nation and our civilization—the home."

In the course of its many papers and its searching discussions, the conference had a look at the slums in rural areas and at the grim, gray ghettos in the cities, both proliferating at an unbelievable rate not only in the United States but in the entire world. It looked, too, at middle class and upper class homes teetering on the brink of dissolution. And it saw scores of examples of these pictures being brightened, of destructive forces deflected or dissipated, of families and individuals strengthened, by the imaginative application of homemaker services.

So varied are the circumstances, so differing the forms, in which the soundness and worth of homemaker services and the contribution they can make to American life today have been demonstrated, that this conference reached one inescapable conclusion: "the acute and pressing need for expansion of homemaker service throughout the United States."

Unless proven and tested evidence is denied, unless the nation chooses to ignore the lessons so well documented by experience all across the land, homemaker service is today on the threshold of a period of great development and enlarged service. Can this country afford to let apathy or ignorance of these lessons prevent the full employment of a tool which it is clearly indicated can strengthen its homes and its individual citizens?

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[*] *Summary from REPORT OF THE 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES, published by National Council on Homemaker Services, 1965.*

Homemaker service is adding a new dimension to total treatment, both in health and in social services. Its value in supplementing both physical and social therapy has been amply shown. In meeting people's needs for homemaker services, communities are seeing how essential is a coordinated approach by all community services seeking solutions to human problems. As America belatedly takes a hard look at the growing poverty in the midst of its affluence, homemaker service is demonstrating that it can be a potent weapon in attacking this insidious weakener of the nation.

Homemaker service gets close to the needs of people and their insufficiencies because it lives their day-by-day lives with them. And because of this, it clarifies what their real lacks are and gives impetus to more effectual application of all services.

Perhaps because of its intimate involvement in people's lives, its focus tends to be the total person. It therefore fosters a more coordinated approach to people's problems.

Service Should Be Designed for Total Person

Recognition is growing—whether the view be from the vantage point of concern with physical problems or those which are social and psychological —that people function as total beings; therefore, therapy must be based on the total individual in his relation to his environment. Homemaker service can contribute to the accomplishment of this and to the overcoming of fragmentation in society's efforts to help its members.

Such steps may lead to the path of "regaining the community through intelligent neighborliness." There is general recognition now that in the development of today's highly urban, highly mobile, highly impersonalized society, a great deal was lost. Many of the social satisfactions and environmental controls and much of the interdependence which existed in the largely rural, more stable and less time-pressured society of earlier times are missing today. Yet the patterns of other days cannot be imposed on a social and economic structure which is so vastly changed.

Perhaps homemaker service can be one help in the development of new patterns which will, through other means, re-establish some of those lost values. Perhaps it *is* possible through "intelligent neighborliness" to find new ways of constructing channels for concrete expression of men's interdependence which will fit the structure of present-day society.

Homemaker service provides one means for reaching the people who in today's social organization are closed off from the rest of the community through poverty, illness, age, or disability, and bringing them in again. Through its dependence on total community involvement, homemaker service can bring to people an awareness of those disadvantaged members of society and their problems. With that will come greater understanding of the influence of this large group of people on total community strength.

Helps to Build Respect for Family and Home

Perhaps homemaker service may also be one means of helping *all* the American people regain their sense of the dignity and primary value of the family and home, and respect for all homes in their communities. "We need to remind ourselves of our humility and reverence in the presence of values and spirit in the most abject homes," one speaker pleaded, "and also of the threat to society from their absence in the most affluent homes."

Such potential values of homemaker service—and there may be others as yet undiscovered—can only be realized, however, if such service is available in every community throughout the country, whether it be metropolis, city, or hamlet. People at this conference talked about the need for at least 200,000 homemakers—and one speaker estimated 500,000. And the homemaker must be equally available to those who can pay full cost, those who can pay only part, and those who can pay little or nothing.

Such widespread development can come about only if the knowledge gained by those who have been testing and learning about homemaker service in scores of separate efforts can be communicated to many people throughout the country.

It is hoped that this report may make some contribution to wider awareness and conviction about this "valued and proven service." Further, that the information it contains may perhaps be helpful to those who undertake to extend homemaker service to thousands more Americans.

Section II

The Various Patterns of Homemaker-Home Health Aide Service

Discussed in several of the papers chosen for this section are principles which can make the homemaker role and function creative in various settings.

The care of young families during the mother's illness or absence was one of the first patterns of service to develop. The first two statements presented in this section emphasize some of the major concepts which underlie the creative utilization of homemakers in the interests of the children in such families. From this task of "bridging the gap" for competent young families, homemaker service has moved on to adapt its function to serve families with special limitations and handicaps. The third paper directs attention to the homemaker's function with single-parent families, including unmarried mothers, and in situations of neglect. In some of these neglect situations the homemaker takes on the particular function of being a disciplined observer who can provide for the other members of the helping team a more substantial and intimate understanding of the interaction within the family. This crucial contribution can help form the basis for sound decisions. However, the homemaker herself may carry out a major role as a concerned and accepting teacher, helping persons of limited background and experience to understand how to function more effectively as parents and home managers. The description, in the fourth paper, of the homemaker as the "culture-bearer," opening new horizons for certain families who function inadequately, presents a new educational approach to a group which the community seldom reaches effectively. Examination, by another author, of the use of homemaker service with migrant families highlights the potential for adapting the pattern of service to the specific needs of a long-ignored group.

Two further adaptations of homemaker service to meet special needs are presented in a social worker's description of service to families with retarded children and a psychiatrist's discussion of the homemaker's role in families coping with mental illness. In both papers the coordination and integration of inter-disciplinary efforts becomes of crucial importance. Another author examines homemaker services for the aged and chronically ill, one of the oldest and most extensive uses of homemaker service.

Homemaker Services — Major Defense for Children*

by Maud Morlock
Consultant, Children's Bureau
U.S. Department of Health, Education, and Welfare

When the idea of homemaker service emerged in the 1920's, it was seen largely as a way to keep children in their own homes during the temporary hospitalization of the mother or her absence from the home for other reasons. Sending a competent woman into the home to carry on in the mother's absence was regarded by the originators of the idea as far better for children, parents, and agency, than foster care.

Over the years the concept of how homemakers can help in strengthening services for children has also grown as welfare and health agencies have experienced their value. Today homemakers operating under the supervision of social caseworkers help families and children during the temporary illness of the mother whether or not she is away from the home. They may be put in a home for a long and indefinite stay, as in instances when a mother has entered a tuberculosis sanitorium or a mental hospital. In such instances the homemaker may come into the home before the mother's departure so that the two can learn to know each other and so make the transition easier for the children; and she may remain in the home after the mother's return, thus assuring a sounder period of convalescence.

Casework Is Cornerstone

In a good homemaking service the caseworker, the homemaker, and the parents can comprise a team working together in the children's behalf. And casework is the cornerstone of the service.

When this is understood, the frequently encountered confusion of homemaker service with "maid service" disappears. Inability to pay is not a criterion for eligibility for the service in most agencies. The basic criterion is the family's need for help with problems antedating or growing out of the present difficulty, including assistance in the care of children and in housekeeping. This means the need for the presence within the family of a person who is not only a good housekeeper but also a warm, understanding personality who can look after the children with an awareness of relationships—a person who is in many respects like a "foster mother" serving from within the child's own home.

**Excerpt from an article in CHILDREN, Vol. 4, No. 3, May-June 1957, published by Children's Bureau, U.S. Department of Health, Education, and Welfare.*

The importance of casework in a homemaker service comes from the need for counseling on the part of a parent struggling to keep his home together under the emotional strain of circumstances threatening to break it; from the agency's need for assurance that the homemaker will be the best one for the children; and from the need on the part of all applicants for homemaker service—whether eligible for the service or not—of some sort of considered discussion of the problem which brought them to the point of application.

Thus, the caseworker contributes in a variety of ways, depending on the particular circumstances, to the family's ability to carry on, and to the experience and skill of the homemaker. At the point of initial application she helps the parent or parents to understand what a homemaker can and cannot do and to consider whether homemaker service is the best plan for meeting their own and their children's needs. Since illness, death, and handicapping conditions are often accompanied by economic, social, and emotional problems, many families using homemaker service want continuing consultation with the caseworker.

The caseworker also plays a key role in selecting the homemaker best suited to a particular family, in her training and in her supervision. She uses her casework skill to broaden the homemaker's general understanding of how to get along with children and adults and to help her adjust to a particular family.

Two Selection Processes Are Necessary

In those agencies providing organized homemaker services, two selection processes are involved—selecting a group of women to become a regular part of the agency's homemaker staff; and selecting a homemaker to meet a particular family's needs. Through the employment interview, the caseworker tries to learn whether the prospective homemaker can enter into the life of another family without becoming too emotionally involved in its affairs, whether she is patient and tolerant with people and wise enough to know when a change in the family's pattern of living is indicated. The caseworker helps the homemaker to see her work in relation to the agency employing her and be able to work as a member of the team. In some agencies this team includes a home economist who helps in the training of homemakers and may give consultation on home management.

For the social worker, the process of recruiting a prospective homemaker is similar to the process of finding a foster mother; and the process of nurturing the ability of each to carry out her task is essentially the same. This nurture may be carried on through group meetings within the agency or in individual contacts between caseworker and homemaker or both. Because group meetings are so difficult to arrange in rural areas, the agencies supplying homemaker service to such areas may have to rely on individual interviews in helping homemakers grow in their understanding of children and parents.

Somehow professional workers must find a way to help communities recognize the importance to a child of his own home so that they will make homemaker service an essential part of community health and welfare programs throughout the United States. Such a service is not a frill to be considered as a possibility after all the other essential services required are made available. It is a major line of defense for children whose security is threatened.

Creative Uses of Homemaker Service[*]

by Nora Phillips Johnson
Director, Foster Care Services
The Children's Aid Society
New York, N. Y.

Originally designed to help families where the mother was ill, homemaker service has now been extended to meet various family crises, when otherwise the children would have to be placed away from home, or might be neglected.

The service is based upon the fundamental principle that children develop to their greatest potential when they have a loving relationship with their own parents. Children who have not formed positive relationships with their own parents or parental surrogates have little realization of "self." These are the children who all through their lives tend to mirror others. These are the children who are without conscience and who may take advantage of others or may seek revenge on society in their search for fulfillment.

Children tell us—not always in words, but often in their behavior—how much their parents mean to them. Child placement agencies are familiar with the distress of the child who cannot release his own parents, regardless of how inadequate they may seem to others. The child's identification with them is frequently so close that he can preserve his identity only by undermining his placement and remaining in spirit with his own family.

Although children are affected by parental neglect, discord and illness, they rarely understand why their home has to be broken and they have to leave. They often blame themselves and excuse their parents. Their feelings of being unloved, worthless and "thrown away" hinder them from forming close relationships in foster care. Some foster children who have not been able to form a satisfying parent-child relationship engage in a heartbreaking search for the parents who abandoned them or drifted away and became lost during placement. Research in all fields of child welfare, including findings by social workers, confirms the importance to the child not only of having a clear understanding of who he is, who his biological parents are, his value to his parents and the status the family has in the community, but also of living with his own people.

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[*] *Reprinted, with permission, from CHILD WELFARE, Vol. 35, No. 1, January 1956.*

The principle that children develop best in their own homes can, however, be meaningless unless it is applied with knowledge of the qualities and influences that contribute to a child's social, emotional, and physical development. It is not enough, therefore, to use homemaker service merely to keep children in their own homes. The decisions must be based upon an appraisal of the family's ability to give the child care, and upon skill in helping the family to maintain, restore, or achieve healthy relationships.

Direct Help Given to Children

A major concern in child welfare is how to offer help to children before their families fall apart. Supervised homemaker service provides a natural avenue for early discovery of destructive family relationships. Giving families a tangible service of immediate practical value often makes them more receptive toward help with less obvious problems.

From its early limited use, homemaker service has been expanded because of the recognition that the flow of family life can be disrupted by adverse happenings to other members of the family, as when the father or a child becomes ill and taxes the mother. In such situations the homemaker helps the mother to maintain the home and care for the other children.

Another concept which has extended the use of homemaker service for children is our growing appreciation that a child needs love from his father as well as from his mother. A close, confident relationship between father and child may be the most positive and determining factor in the child's life. In separated families it is often the father who remains constant in his devotion to his children. The influence of fathers in child development is also seen where a child's problems are due to a poor relationship with his father. In the past few decades, fathers have been freeing themselves from their culturally determined role, which tended to separate them from their children, and are participating more actively in their personal care and guidance. Helping a father and children stay together can have profound emotional meaning to children. The father's wish to keep his children at home may be impractical or even destructive. In planning separation, we must understand the normal needs of father and child for each other. It is true that a home cannot be complete with father, children, homemaker and caseworker. However, alternatives must be considered from the child's point of view. The homemaker cannot take his mother's place, but she can give mothering, and children respond to human warmth wherever they find it. Through the use of homemaker service, the child is spared the loss of both parents, the comforting familiarity of his own home, neighbors, school, Sunday school, and his friends—in short, his entire known world.

Service Is Aid in Foster Care

Foster care agencies are finding homemaker service a valuable aid. Not only may homemaker service in a family where children are in danger of losing their own homes often avert placement or protect children from unwelcoming relatives, but when the decision for placement has already been made, the shock of abrupt separation for children and for parents can be minimized. Time is allowed for the children and the adults to encompass what is happening to them and to participate in effecting the change. In the child's own setting, important information for planning can be obtained. In some situations referred for placement, the use of homemaker service has enabled children to remain with their own families. However, homemaker service cannot be a substitute for placement, if placement is what the child really needs. When the quality of the child's relationships and the conditions within the home are such that his own family cannot provide the essentials for his well being, the child should be given the opportunity for a good living experience in an environment where he can develop.

Homemaker service is used in foster homes when the foster mother is ill or has to be away from home. Placement of a homemaker can spare children the painful experience of repeated separation. When the foster child's natural family is to be reunited, particularly in families where the mother has returned home after long hospitalization for either physical or mental illness, homemaker service can help in easing the stress of readjustment.

Day care agencies report that the use of homemaker service when children are ill at home lessens the anxiety of mothers who can function as mothers only because they are able to work.

Protective agencies are beginning to use homemaker service on a 24-hour basis instead of sending a child for detention care away from home. In Aid to Dependent Children programs where casework service is limited or non-existent, supervised homemaker service can be the entering wedge of help to children in these families.

Health agencies are requesting homemaker service for families with a child who is blind, has cerebral palsy, a heart condition or other physical handicaps. The special care, treatment and guidance he requires may impose excessive fatigue and psychological strains on the mother. Recognizing the part that closeness to parents plays in the recovery of sick children, health agencies are also using homemaker service to help the mother provide convalescent care of a child in his own home.

Child guidance clinics and other psychiatric services are calling upon homemaker service to help in families where a child who, in treatment, requires so much more of the mother's time and energy that she needs some relief from excessive burdens in order to function.

Service Determined by Need

Awareness that the length of any service for children and their families must be flexibly adapted to their needs is leading many agencies away from rigid, predetermined time limits for homemaker service. In some situations forecasts at intake about length of service can be relatively accurate. However, there are many times when family relationships, resources and failures become clear only during service. As old problems change, new ones develop and unforeseen solutions emerge, length of service should be adjusted. The favorable experience of agencies which have offered homemaker service for varying periods of time, determined by the needs of the family, is helping to dispel fears about the wisdom and expense, even of long-time service for children. Homemaker service, like all social services, should be continually appraised for its values to the family.

In summary, some of the child welfare concepts which have broadened the use of homemaker service for children are:

1. the importance of preserving the child's identity
2. the importance of the mother of the family
3. awareness that family life can be dislocated when any member is afflicted; therefore, though a mother is not ill, the homemaker may be needed to keep the family intact
4. the need to find ways of helping families with their children before the family breaks up
5. the influence of fathers on the social and emotional growth of their children
6. recognition that length of service must be flexibly adapted to the needs of a child and his family.

Planned with foresight and used with conviction, homemaker service can be the means of helping more children live with courage and confidence.

The Use of Homemakers to Improve the Care of Children*

by Louise Foresman
Homemaker Supervisor, Child Welfare Service
St. Louis (Mo.) County Welfare Office

Children deprived—physically, emotionally, educationally; children rejected; children battered and abused: these are the children who today are desperately in need of "extra" service. Intensive help from the caseworker-homemaker team is essential if these children are to survive and, beyond this, become adequate and understanding citizens of tomorrow.

Over 50 years ago, the White House Conference on the Care of Dependent Children stated: "Home life is the highest and finest product of civilization. It is the great molding force of mind and of character, and children should not be deprived of it, except for urgent and compelling reasons."

This is still the foundation of thinking in the child welfare field and it remains the broad base of all protective services for families in which children have not been receiving the care they need. Today, in reaching out and offering casework help which is not requested and which is sometimes not even understood, we work with parents with the aim first of helping them to understand their problems, and then of strengthening, supplementing, and supporting their efforts to improve conditions for themselves and their children to a point where they meet at least the minimum standards of the community—thus making it possible for the children to remain in their own homes.

More and More Families Need Help

In St. Louis County (Mo.), the public child welfare caseload has been averaging some 1,300 children per month—more than half of whom receive protective service in specialized caseloads containing from 28 to 33 families. Over the years, as outside demands on families have become much greater, with stresses consequently intensified, we have been servicing an increasing number of families who need help desperately; families whose problems are serious, of long standing, and consequently overwhelming; families in which the parents are immature, inadequate as parents, mentally ill or limited, and unable to cope with their ever-present day-to-day problems. With increasing

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From "Strengthening Family Life," a paper presented at National Conference on Homemaker Services, Washington, D.C., April 29-May 1, 1964. Published in CHILDREN, Vol. 12, No. 1, January-February 1965, Children's Bureau, U.S. Department of Health, Education, and Welfare.

frequency, we find that by the time these families become known to us their problems have been aggravated by repeated parental failures due to physical, economic, marital, and emotional problems.

As has been pointed out, the emotional development of children, still the prime function of the family, is the most complicated for parents to understand and cope with. This is all the more true when family life is complicated by parental failure and by the fact that the family's undesirable emotional climate—with resultant emotional damage to the children—is of long standing, and has developed to a crisis stage. The entanglement of the parents' inadequacies with the unacceptable behavior of their sick children makes it very difficult to begin service and be of real help.

It follows, then, that the agency's concern for the welfare of children must necessarily be reflected in expanded, more flexible service: service far beyond what a caseworker, carrying a full load of complex, involved, multiproblem families, can possibly offer through brief visits to the family once, or even twice, a week; service which is imaginative, and derived from an ability to improvise and to cope with whatever one finds, whether poor housing, lack of food, lack of essential facilities, or the more difficult factors of parental immaturity, irresponsibility, indifference, and perhaps hostility, or serious physical illnesses and disabilities, mental illness, or mental limitations within the family group.

When giving protective service, one must sort out and weigh all these factors in relation to their effect primarily on the children. The question is, "How does one begin to cope with these long-entrenched problems?" and, more essentially, "How does one motivate and involve the parents to begin to help themselves and their children?"

The Caseworker-Homemaker Team

Obviously, the team approach of caseworker-homemaker is one workable answer, with homemaker service offered, and used, as an adjunct and supplementary service to protective casework.

A well-selected and supervised homemaker may, in many family situations, fill the need for a substitute parent—a warm, accepting "other" adult who can be a benign maternal figure for the child and his immature parents. Being a part of the family interaction—8, 10, 12 hours a day, and at regularly scheduled intervals each week—the homemaker can help organize the household; wash and iron, to make it possible for the children to attend school; even wake them, give them a warm breakfast, and see that they make the school bus. She can mend clothes for the children, teach teenagers how to make their own clothes, and help mothers learn better household management.

But far beyond this, the homemaker can appraise the situation as it really is; understand what the family considers its most pressing problem and what its members feel they can do about it; and observe what, in fact, goes on. This factual information, colored with the sometimes intense feelings of the parents and overlayed with the homemaker's reactions and feelings, can be shared in conference with the caseworker, whose training, insight, and understanding of human behavior permits her, with her own knowledge of the situation, to make the casework decision essential to action and eventual improvement in the home.

In the caseworker-homemaker team, caseworkers and homemakers alike must assimilate certain convictions basic to the philosophy of protective services and make them an integral part of their skills. If they are to do an effective job, both must be convinced that:

1. most people have an innate capacity to be good parents and really want to be adequate,
2. there is an "inner core of positives" or strengths in each person,
3. parents do have the capacity to change,
4. parenthood is a privilege and can be a satisfying experience,
5. children need mature, warm, and understanding parents,
6. through well-timed interest and challenge, parents can often use help given by the worker and homemaker and so begin to improve the care of their children,
7. the triad of worker-homemaker-parent is the most important tool in protective casework services—the closer the team and the family agree on what is needed and wanted, the more strength there is upon which to build.

Since every unhappy family is unhappy in its own way, how the caseworker-homemaker team functions in each family where children have been neglected or abused must be an individual casework decision. But more teamwork of this nature is necessary if the individual and complex patterns of family unhappiness, which have such devastating repercussions on children, are to be understood and alleviated.

The Use of Homemakers to Help Families Raise Their Level of Living*

by Johnnie U. Williams
Homemaker Specialist, Bureau of Family Services
U.S. Department of Health, Education, and Welfare

Using homemakers to help families *raise their level of living* is one of the most exciting departures from traditional practice.

Let us clarify what we mean by "raising the level of living." It does not mean that we expect to provide public assistance families with luxuries, or with the same food, clothing, or housing which middle income families have. It does mean that we seek to help them have nutritious food in sufficient quantity; clothing which is suitable for their needs; and housing which is clean, safe, and conducive to the kind of family life which stimulates healthy physical and mental growth of children.

All of us have struggled with the problem of helping families who bear the brunt of community criticism. These are the families whose children seem unable to learn; who go to school dirty and without lunch. These are the families who make meals of cold cuts and crackers, of soda and cookies. These are the families who make very poor use of their limited assistance grants, and who can never plan for a month ahead.

". . . But Nobody Shows Me How"

As caseworkers we understand that this is not a simple, uncomplicated problem. We know that many such families live the way they do because they have had no opportunity to live differently. We know that parents repeat with children their own life experience. This was the situation with Mrs. Harvey when she poignantly said, "Everybody tells me I don't take good care of my children, but nobody shows me how."

> Mrs. Harvey's situation was referred to the agency by the police who alleged that she was a neglectful mother and recommended that her children "be taken away from her and placed in foster homes at once!" The police had been called to her home the previous night, upon complaint of neighbors that Mrs. Harvey's six children, ranging in ages from one to six years, were alone in the apartment and were not being cared for. The landlord claimed that this was a frequent occurrence. The police described Mrs. Harvey's children as dirty and unkempt. The two-year-old twins were unclothed except for undershirts. They had remnants of feces on their bodies, and were sleeping in a bed with a worn-out

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From "The Caseworker-Homemaker Team," a paper given at American Public Welfare Association, Southwest Regional Conference, New Orleans, La., 1965.

dirty mattress. The baby was nursing a bottle of curdled milk. All of the children seemed to be underweight and malnourished.

Mrs. Harvey was hostile toward her landlord for reporting the situation to the police whom she felt had made an unfair evaluation of the previous night's incident. She was resigned to the possibility of having her children removed, but defended her care as being the best possible under the circumstances.

The caseworker's social study disclosed that Mrs. Harvey was a 23-year-old woman, who came from a deprived background. Her first child was born as the result of a criminal attack at the age of 13. (This was verified by court records.)

Subsequently, she was married and her second child was born. After a brief period the marriage ended in divorce. Mrs. Harvey then began a relationship with Mr. Simmons, a married man many years older than herself. Four children resulted from this relationship.

Mrs. Harvey was completely dependent financially upon Mr. Simmons, who provided support within his means. A year before the neglect complaint was made to the welfare department, a fire left her almost entirely without household furnishings or clothing. Though pregnant, she had rescued her children from their basement apartment.

The caseworker suggested the assignment of a motherly homemaker who, on a day-to-day basis, could teach Mrs. Harvey how to give better care to the children and the home. Together they were soon bathing and dressing the children, cleaning and organizing the home, and making the best use of the limited clothing and household furnishings and supplies Mrs. Harvey had. At the same time the caseworker saw to it that immediate needs of food, clothing and household supplies were met. In addition, the caseworker established Mrs. Harvey's eligibility for an AFDC (Aid to Families with Dependent Children) grant which supplemented the support from the former husband and Mr. Simmons. She helped Mrs. Harvey and Mr. Simmons to establish paternity of his children and, thus, clarified their legal status.

Over a period of months, the caseworker-homemaker team worked with Mrs. Harvey. This is what they accomplished:

1. The homemaker, through her close contacts in the home, learned exactly what basic essentials in clothing, bedding, dishes, cleaning equipment and cooking utensils, were needed by this family and the caseworker tapped community resources to meet these needs which required large immediate outlays of money.

2. Mrs. Harvey learned by the homemaker's example, to give better care to the children, giving attention to their diet, hygiene, rest, and supervised play. The caseworker helped Mrs. Harvey to secure medical care.

3. The homemaker helped Mrs. Harvey to learn to shop better and to plan expenditures, now that she had a predictable, though limited, income.

They watched for bargains, budgeted, and went shopping together.

4. When Mrs. Harvey began sharing with the homemaker her changed feelings toward Mr. Simmons, the homemaker listened sympathetically, but encouraged Mrs. Harvey to seek counsel from the caseworker. As some of her most pressing problems were relieved, Mrs. Harvey began to think of the future in terms of greater satisfactions for herself and her children.

In the case of Mrs. Harvey we can see an important by-product of homemaker service—the change in attitude, the change in perception of self, the look toward the future with greater optimism which results from increased feelings of self-reliance in dealing with one's life situation. Mrs. Harvey said, "I didn't know I could feel so good and still be poor."

Over and over, in literally thousands of cases of this kind, the homemaker, working in practical ways within the home itself, serves as an agent of change, a "culture-bearer." She is close to the family in unguarded moments. She knows them in intimate ways that the caseworker could hardly be expected to know. And the homemaker carries out her role not by exhortation, but by demonstration. Thus, the homemaker contributes to the caseworker's plan for helping families raise their level of living.

Homemaker Services for Migrants*

by Georgia P. Hughes
Director
Carteret County (N.C.) Department of Public Welfare

This is the third year the Carteret County Department of Public Welfare has employed homemakers to work with the crews of farm workers who come to the county for about two months each summer to harvest crops consisting of cabbage, potatoes, beans and blueberries. From 800 to 1,000 laborers come each season, often bringing their children with them. They arrive in trucks, old buses and automobiles and live in barns, abandoned houses, and an old fish house. In only one instance is a camp built especially for them with a community room equipped for cooking. In all of the camps,

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Paper given at Annual Homemaker Workshop, Raleigh, N. C., August 1963, published in PUBLIC WELFARE NEWS, Vol. 27, December 1963, North Carolina Department of Public Welfare.

except the last one mentioned, there are no facilities for cooking and the people must depend on oil stoves they bring with them and outdoor fires. Most of the camps have beds with thin cotton mattresses but some have no beds and the laborers sleep on old mattresses or on the floor itself. The crews are sometimes family units, but are generally made up of workers recruited by the crew leaders in various ways.

One of the first things we learned was that a crew is not a group of individuals interested in working together to improve their living and working conditions, but is made up of individuals, couples, or families who provide separately for themselves the best way they can. The crew leader and his family usually arrive well provided with stoves, mattresses, and bedding. Some of the crew leaders boast of the material possessions they have accumulated and our general impression is that their earnings are good. Our impression is that the laborers earn just enough to keep body and soul together. They appear to remain constantly in debt to the crew leader and at least one crew leader has told us that this is one way he keeps his crew together. The crew leader provides transportation for the workers to the area. He makes the deal with the farmer, sometimes through the farm placement representative, and pays the crew.

More Than Two Million People Are Migrants

We understand there are two and a half million people in the country who make their living in this way. Most of them on the Eastern Seaboard are in Florida four or five months out of the year and then move on up the coast as far as Maine before they return to Florida. They always live in labor camps and carry all they own with them in suitcases or boxes. The children go to school part of the year but change schools often and miss a great deal. In Delaware and some of the northern states, summer schools are provided for them in some of the larger camps.

In Carteret County the migrant workers are Negroes and Indians. In the west and north, migrant workers are mostly Mexicans, Indians and whites. In Carteret County perhaps one-third or more of our migrant workers have homes they go to in the winter.

The people who have homes and are residents in a state do not present the same problems as the other migrant workers. If they become ill, unemployed, or run into various other difficulties, they may be returned to their home state or home community where they can go to a local welfare department for assistance. The others, the migrant workers who stay on the harvesting stream the year around, have residence nowhere. Most of them came out of Alabama, Mississippi, Georgia and South Carolina years ago when they were pushed off the farms due to mechanization. They went to Florida, following tales of easy living and abundant crops. Some of them still seem to believe in this dream and think that next season they will make a great deal of money. Some of them are apparently content with the life they lead, make the best of it, or perhaps even enjoy the freedom from responsibility. The majority appear to be caught in an economic struggle for survival and unable to find a way out. They have no skills to offer in other types of work and cannot compete with residents for local jobs. They are at the mercy of the crops, the weather, and the crew leader. They lack residence in a state that gives them the security of being able to go to a local doctor, law enforcing officer, welfare department, or health department for help when needed, as other low-income groups do in an emergency.

Helping Migrant Families Is Unpopular Job

Working with migrants is an unpopular job. The crew leaders do not want interference with their control over their workers. Services to the migrants might make them less dependent upon the crew leader. The farmer apparently fears the criticism of the groups attempting to help the migrants because these groups want legislation to enforce improved housing for the people. Local agencies (welfare departments included) are already overburdened with the needs of their own local citizens and find it difficult to assume responsibility for another program such as services to migrants. This is true in Carteret County as well as elsewhere.

The homemaker program with migrant workers has been different each year. It has almost been different each day. We set very general goals to help the people improve their living conditions in regard to sanitation, nutrition, and child care. There were many problems in attempting to reach these goals. The first one was the suspicion of the people who questioned the reason for the homemaker's concern for them and apparently feared and distrusted anyone from the local community who came into their camps. This has been partially overcome in the three years of working with the migrants but is not completely dispelled.

The second big problem was time. The people worked in the fields when the crops were ready and when the weather would permit, from daybreak until sunset, and often into the night at the potato graders. The third big problem was a place to work with them as the camps are crowded, dirty, and have no central room for a gathering or conference. The homemakers had to use ingenuity and initiative in working with the people. It was difficult to have a work plan or to follow a schedule. They had to work irregular and long hours. They often had to encourage themselves with the reminder that anything the agency did to make these people feel a part of the human race and our society (even if it was only a smile or a handshake) was an accomplishment.

The first year the homemakers gathered the children off the ditch banks or out of the trucks and set up a makeshift day care center in one of the camps. This was not satisfactory because all of the children in the county could not be brought to this camp to be cared for. There were not proper facilities for adequate care or play and the health needs of the children were not met. It only kept them from having to go in the fields with their parents and provided some supervision and attention. That year the homemakers also visited camps to nurse sick children and adults, to do a little cooking, and distribute used clothing donated by the Ministerial Association. The next year the homemakers worked more closely with the mobile medical unit. During this season, a baby's life was saved by the alertness of the homemaker in taking the baby to Duke Hospital for treatment.

Day Care Center Changes Conditions

This year the homemakers' approach to helping the migrants was changed drastically by the opening of a licensed day care center that enrolled 44 children and gave care to an average of 25 children a day for five weeks. These children were from two to 10 years in age and came from nearly every camp in the county. One of the homemakers, with the help of the home demonstration agent, did the planning of the meals and the cooking and serving of meals at the day care center. She also acted as the go-between from the day care center to the camps. She often picked up the children in the morning and took them home at night, which meant that she worked from 10 to 12 hours a day.

The other homemaker with the program this year was a home economics teacher who worked at the medical clinic at night, getting histories for the doctors and keeping records and then following through on delivering medicine and seeing that the patients followed the doctors' orders. She also visited the camps during the day to show films borrowed from the State Health Department on the basic needs for proper sanitation, nutrition, feminine hygiene and child care. These films helped her in establishing a relationship with the people and an opportunity to have private conversations with individuals about their needs. In one camp, as a result of a film, a mother showed her a tiny baby who had never been exposed to sun and exercise and was not being properly fed. The baby had never regained his birth weight though he was several weeks old. The homemaker encouraged the mother to bring the baby to the mobile medical clinic and then to follow through on the doctor's instructions in regard to sun, exercise and proper feeding. Within two weeks the young mother brought her baby to the homemaker to show how much he had improved, thank her for her help, and to give her names of other women who needed help in regard to giving their children proper care.

During all three seasons of homemaker services to migrants, the homemakers worked closely with the Migrant Committee in the county, which consisted of representatives from many local agencies, led by the Carteret County Ministerial Association. Staff conferences were held regularly with all the people working with migrants under this committee, including a minister, and the two women who operated the day care center. The services offered were counseling by ministers, the distribution of used clothing, the homemaker services and the facilities of a mobile medical unit and a day care center.

Those of us who have worked in this migrant program became interested in this particular group because they are an economic necessity in our society and have been discriminated against because of their lack of residence in a state and the right to services offered by a resident state to its citizens. As the program has developed and increased in scope, services have been offered in Carteret County for six to eight weeks to these people—services not available to them elsewhere and not available to the residents of our county. We do not have a day care center in Carteret County for children whose parents work and we do not have a free medical clinic for residents. There have been questions asked in this county about why these people should be given services not available to local residents. Our answer to them is this: "Their need is greater because their lack of residence denies them the right to ask for or demand services available to a legal resident."

Homemaker Service in a Voluntary Agency for Families With Retarded Children*

by Rose Brodsky
Executive Director
Association for Homemaker Service
New York, N. Y.

In recent years there has been a strong movement toward recognition of the needs of the retarded and their families. Our purpose here is to examine how homemaker service can become integrated and accepted as one of the basic services geared to the specific needs of these families, along with the more developed services offered, such as clinical diagnostic services, educational, institutional, and other placement services.

Our agency, the Association for Homemaker Service, was organized in New York City five years ago, as a family-centered casework agency with homemaker service as its sole function. It is a voluntary agency, independent, non-sectarian, non-profit, and city-wide.

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*Paper given at National Conference on Social Welfare, Chicago, Ill., June 2, 1966.

As a new agency we were determined not to be bound by tradition. Our development of program was to be geared to community need, though budgetary considerations form natural boundaries. Thus our gamut of homemaker service is multiple and varied, all based on the essential purpose of helping to maintain individuals and families in their own homes, where this is the best and most desirable plan to accomplish a health and/or social welfare goal.

We began with child care, and soon expanded to include the chronically ill, the handicapped, and the elderly. We did not impose an arbitrary limit in terms of number of hours given, or length of service. We permitted the needs of the client to shape our policies, and did not force him into alternatives which would be unacceptable to him, provided homemaker service was a suitable plan. It is patent that in many situations community responsibility for long-term care is inescapable. Dependent children cannot be abandoned. Some chronically ill and handicapped need help for much of their lives. The needs of the elderly often increase with time.

Service Not Viewed as Panacea

In our work as a homemaker service agency, we do not view our service as a panacea. We value other services, such as foster care and institutional services, as essential. Our philosophy is that clients should have a true choice from among the available constellation of services, including homemaker service on a flexible basis, with casework help to assist them in attaining a solution most meaningful to them. In keeping with this approach, our service is offered from part-time up to 24 hours around the clock, on all or any of the seven days of the week, for so long as the service has purpose for the family toward accomplishing valid objectives, no matter what the time span, even in terms of years. It can be preventive, rehabilitative, educative or supportive, and is used on a differential basis. Homemaker service alone might accomplish the goal. Often it serves as a diagnostic tool, with the caseworker helping the family determine and move toward a plan more suitable for it.

Our homemakers are staff members, recruited, employed, trained and supervised by the professional social work staff, which insures the professional quality and continuity of service. Their guaranteed salary and fringe benefits also contribute toward staff stability. The uniform worn by the homemaker attests to her agency status. Nine homemakers are assigned to each caseworker. Together, caseworker and homemaker form an integrated team, each with her own discipline, to accomplish the goals of the service.

The job of the homemaker is composed of two aspects—the psychological and the concrete. Her job is a unique combination of clearly and carefully selected tasks which are comparable to, but not identical with, elements in the work of the social worker, nurse, companion, housekeeper, assistant to the parents, substitute parent, and household worker. Because of some overlap, the function of the homemaker is often confused with the others mentioned above. Yet there are many responsibilities carried by the other disciplines which are clearly proscribed for the homemaker. Those tasks specifically defined for her, both tangible and psychological, combined with her teamwork with the caseworker, constitute the homemaker's job in our service. The caseworker places and supervises the homemaker in each household. She integrates the role of the homemaker in her casework process with the family. Her focus, in working with the family, is on the use of the service itself, and those individual and family problems which might emerge or result from the impact of the situation necessitating homemaker service. The caseworker also coordinates our work with that of any other discipline or service involved with a given family.

Other Agencies Purchase Service

By the end of the third year, our agency had built a staff of 110 regular homemakers, 30 additional for relief coverage, and concomitant professional and pre-professional staff. The unexpected and rapid expansion of our agency was made possible in large measure by the purchase of service by several public and voluntary health and social agencies.

It appears that national health agencies and foundations concerned with a particular disease or handicap tend to focus on research, diagnosis, treatment, appliances, and concern with placement facilities, some educational and rehabilitative. There seems to be a reluctance by many to offer homemaker service. There are some exceptions. In our own experience, the American Cancer Society, New York City Division, which had been placing its own staff homemakers under the administrative supervision of a nurse, gave that up. Instead, the Society has been purchasing our caseworker-homemaker service for its total program for the past two and one-half years. Its staff does the telephone screening of referrals. Our caseworker then carries casework responsibility from intake to closing, including supervision of our homemaker. There is recognition that while extensive and intensive research to conquer the disease is going on, families hit by the tragedy often need immediate home help. Homemaker service might be the most desirable and economical answer, where it can be an adequate choice, as against placement in a hospital or institution.

Recently, the United Cerebral Palsy Association, in its Annual National Conference, scheduled an all day workshop to examine the need for homemaker service, and how it might be developed for its groups. The one local chapter which started a small service under the supervision of its social work director served as an example of what might be accomplished, not only in meeting a need, but its effect in stimulating fund-raising activities.

The question is whether it might be possible for any of the organizations and foundations concerned specifically with the retarded to review their policies, and consider whether they can undertake some financial responsibility for homemaker service as an integral part of their existing constellation of services. Local voluntary service agencies are often limited in their fund-raising base. The national health organizations might be reaching groups with special identifications and interests. The auspices under which homemaker services are initiated, developed or expanded for families with the retarded can vary, and the structure might well flow from the pattern of organization in any given community. The essential consideration is whether funds can be freed, allocated, or channeled for homemaker service where this would better serve the home care needs of families with retarded children who for so long have been overlooked in this regard.

We were early approached for homemaker service by the Retarded Infants Services, Inc., a local voluntary agency, with several services other than homemaker for families with young retarded children. It had heretofore found difficulty in referring families for homemaker service where the need centered on the retarded person. We accepted referrals, with the Retarded Infants Services contributing a partial fee. Families paid something where they could. Our agency carried the major cost.

The families served had much in common, with variables unique to each. The following case illustrates problems which are experienced by many families with a retarded child:

> A mother, in an advanced stage of pregnancy, could no longer manage. Her retarded child, under three, was large, heavy, severely handicapped, wore braces, needed considerable lifting, and had to be dressed and fed. Despite great love and devotion for this child, the parents had agreed to his placement in an institution as the best plan for him as well as the family. However, there was a waiting period. Two older school-age children were being badly affected by being overly burdened with helping care for their little brother. The father, unskilled, worked long hours, and was not too available for helping. Much had gone into this couple's decision to risk planning for another baby. There was danger of a miscarriage.
>
> The placement of our trained homemaker who concentrated on care of the retardate, and assisted with household tasks, gave immediate relief to the mother and the older children. Only now could the older children have the parental attention they needed. The homemaker, as part of the team, shared with the caseworker her observations about the family's needs and reactions. The parents used their relationship with the caseworker to come to grips with their naturally continuing ambivalence over the retarded child's impending institutionalization, moving toward

some further resolution of their conflict. They could admit concern about their older children, and the risk in having another baby.

The hours of service and the role of the homemaker shifted, contingent on whether the mother was in the home or in the hospital giving birth. The homemaker is trained never to usurp a parental role, and yet assist as fully as needed.

Service continued throughout the mother's convalescence which coincided with the placement of the retarded child. This was a logical ending for the service.

Our joint experience with these cases resulted in a joint three-year demonstration project made possible by a grant from the Children's Bureau of the Department of Health, Education, and Welfare. It was agreed that a demonstration with research could serve to examine the value of homemaker service to families with young retarded children.

Project Pattern Worked Out

The Retarded Infants Services was to be the referral source, with its caseworker doing the initial intake. One of our caseworkers was assigned to place and supervise our six homemakers selected for the project. She also maintained the casework process with the families around the use of the service, with a focus on those aspects of family need and problems created by the reality of a retarded child. When homemaker service was completed, the clients were referred back to the Retarded Infants Services for a follow-up casework interview.

At the outset, the professional staff and homemakers involved in the demonstration were given orientation as a group, which included field visits to clinics and placement facilities for the retarded. Once cases were under our care, our own staff had special on-going training meetings.

While working on the Research Design with the Research Director, it was agreed to set up a second group of cases as a control group. These families would be helped by home aides, through the Retarded Infants Services, a service which it had already been offering. These aides are domestic workers whom they recruit selectively on an as-needed basis. The aide's job is to help care for the children and do light cleaning and cooking. The agency's caseworker was available to these families where they needed help in the relationship to the retarded child, and with regard to planning.

The families who received homemaker service in this project represented a microcosm of the broad spectrum of almost inevitable need in one form or another. Some families had a pattern of denial which blocked them from considering valid placement. Others were so rejecting of the child as to move to placement prematurely, resulting in guilt and excessive conflict. A difference in reaction between parents led to marital tensions. Other children in the family generally were affected by the situation. The introjection of the tangible aspects of the homemaker's help could relax a family so that more balanced relationships might be restored. Also casework help was more effectively utilized. Parents are often too blocked emotionally to help the retarded child realize his potential. The trained homemaker can help him accomplish more. This then might make a definitive diagnosis more possible, which is then a clearer basis for sounder planning in making choices between keeping a child at home, or appropriate placement. And sometimes just periodic relief through homemaker service can make the difference between a plan at home or placement.

The final report firmly attests to the value of both kinds of home services in the demonstration. However, with the differential structure in the two services, homemaker service and home aide service, there were naturally some inherent differences. The cases for both groups were chosen at random. The mother was present in the home for part or all of the time throughout service in all the cases in both groups. Many of the cases had basic similarities. Some showed strikingly comparable results. Others responded with some differences. One thing emerges with clarity. Families with retarded children can benefit markedly from responsible home services under professional auspices, the form and structure naturally determined by the resources in any given community. The final report is available from either our agency, the Association for Homemaker Service, or the Retarded Infants Services.

Project Benefits Entire Staff

An important by-product of our initial readiness to give homemaker service to families with retarded children and our subsequent work in the demonstration has had an impact on the agency staff, as a whole, although only a few were directly involved. The total professional staff was kept related through case presentations and group discussions with casework and homemaker staff. The interest was vital and vivid and stimulated staff growth and development. We now find ourselves attuned to the special needs of these families, regardless of the basis which triggers the need for service; and we apply our newly found skills. In case after case where service is purchased by other agencies for traditional reasons, such as a mother's illness, we find retarded adults and/or children for whom there has been no planning. While we can help with this once we are in there, and apply our knowledge to helping plan for retarded adults or children, we are concerned that these families would usually not have been accepted for homemaker service by the referring agencies were the request based solely on the family's inability to cope with the pressures in planning for the care of a retarded family member. Nor can we account for the numerous families who do not get to services until they are in serious crisis situations.

In conclusion, one might state that, as social agencies, we should be attuned to the needs as projected by families with retarded members. It is from them that we must learn how to serve. We must throw off the shackles of tradition and be ready to develop services as needed although we all recognize this is necessarily contingent on available funds. On the whole, recruitment and training of homemakers pose no insuperable problem. Service should be available on a broad, flexible basis, with no arbitrary time limits. These families should have a valid choice between keeping the retardate at home, where feasible, and if homemaker service can make this possible, or restoring to placement. Families should not be forced into rigid, unacceptable solutions. The voluntary service agencies might redefine policies even within their existing resources. The national and local organizations and foundations concerned with the retarded might explore their possible role in making homemaker service more available to families with retarded members. The auspices and structures can be varied and flexible in both public and voluntary agencies, depending on the pattern in the community and funds available. Homemaker service should take its rightful place as a basic health and welfare service, applied with the kind of creativity and imagination which is inherent in this service. Our thesis is dual—more homemaker service with added scope to include families where the focus of service is necessitated by a retarded family member—and the search for funds from every available source to allow for the expansion and development of such homemaker services, where appropriate, in the voluntary agency.

Homemaker Service in Psychiatric Rehabilitation*

by C. Knight Aldrich, M.D.
Professor of Psychiatry
University of Chicago

Although an emotional illness presents problems of adaptation to members of the patient's family in any circumstances, the problems are most disturbing and far-reaching in their effects on family solidarity when the patient is the mother of young or adolescent children. Children inevitably suffer from separation and loss of maternal support whenever a mother is hospitalized for any reason, but when the mother is mentally ill the children must also cope with their own concept of mental illness: i.e., a condition which to them is certainly mysterious, perhaps shameful, and often treated by friends or schoolmates with derision. Moreover, during the early phases of her illness, the mother's attitudes or actions may have estranged or frightened the children. As a result, the children often develop ambivalent feelings, which are followed by guilt and self-condemnation when the mother leaves for the hospital.

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> Cheryl, aged 6, had been a reasonably well-adjusted child before her mother was committed to a state hospital for treatment of paranoid schizophrenia. Shortly thereafter, Cheryl was reported to be "wistful and clinging, wondering if mother had gone to the hospital to have another baby. She worries constantly, thinks she is naughty and wishes she could go to heaven. She repeatedly asks: 'I have been a good girl today, haven't I?' "

The patient's husband may experience ambivalence, anxiety, shame, guilt, and estrangement, which lead to preoccupation with his own reactions and an inability even to give the emotional support he customarily offers his children, to say nothing of the added comfort they require at this time. Although the husband may receive casework help in understanding his wife's illness as part of the psychiatric treatment program, the caseworker usually focuses primarily on the interaction between the patient and the rest of the family, and gives secondary consideration to the day-to-day problems of the children.

Care of the children is most often assigned to relatives, who may or may not welcome the opportunity. If the plan requires the children to move out of their home, it usually means the loss of many of their sources of security: father, friends, school, and familiar surroundings. If the children are distributed among various relatives, they lose the security of each other's presence. When a relative moves into the house to take over the children's care, consequent tensions within the family may complicate the picture.

Families without available relatives try various alternatives, none of which is completely satisfactory. Housekeepers are hard to find, and prefer to avoid homes where children are upset; the patience of the neighbors wears thin; and there are serious psychological hazards in turning over the mother's responsibilities to an older daughter.

> When Mrs. C was committed to a state hospital, her 12-year-old daughter undertook the care of three younger siblings. In her new role in the home, she conferred with her father about domestic problems and the care of the children, and in other ways took over many of the responsibilities and prerogatives of a wife and mother. Superficially she appeared to enjoy the opportunity to take her mother's place, but at the

> same time her father noted that she had become anxious and apprehensive in her relationship to him, that she complained of insomnia and nightmares, and that she had become unreasonably possessive of the baby.

When other alternatives fail, the father may be forced into placing the children in temporary foster homes, an experience which, however well carried out, cannot help but add another increment of insecurity for the children.

> When a young woman went to the hospital with schizophrenia, her husband, upset, depressed and unsure of himself, made rather precipitate plans for foster home care for their two children. The children, confused, perplexed and distressed, suffering from the loss of both mother and father at the same time, attempted to establish some kind of relationship with the foster parents. Meanwhile, the mother improved and returned home, but became very upset because the children were in the care of somebody else, and insisted on their return. Almost immediately thereafter she relapsed, and the whole pattern repeated itself.

Homemaker Service Described

In many communities a more satisfactory alternative is provided. One hundred and twenty-eight social work agencies in this country provide homemaker service to care for children in their homes when the parental function is impaired. Homemakers are women who are part of the agency staff, who are trained and supervised by caseworkers, and who work primarily in homes where the mothers of young or adolescent children are temporarily and unavoidably absent. Homemakers are chosen for their interest in children, their ability to get along with people, and their homemaking skills. They usually have enjoyed family life and have been successful as parents of children who are now grown. Casework is an integral part of homemaker service; it is used both in determining its appropriateness for the particular family under consideration, and in helping the family to make the best use of the service and to work out associated problems.

Although originally developed to provide substitutes for mothers with physical illness, this program has found gradually increasing application in homes where the mother is suffering from mental illness. In some agencies more than a quarter of all the homemaker assignments involve cases of mental illness. To my knowledge, however, there is nothing in the psychiatric literature which describes the service, and psychiatrists generally either do not know of its existence, or know too little of its nature and indications to work efficiently with the supplying agency. The optimal functioning of homemaker service in families where the mother is mentally ill depends to a major degree on familiarity of the psychiatrist with the extent and limitations of agency services as well as on familiarity of the agency with the treatment goals of the psychiatrist.

The object of this paper is to clarify homemaker service for the psychiatrist. Once psychiatrists know of its existence and understand its operation, I feel confident that they will find it a new and valuable adjunct in the treatment and rehabilitation of many of their patients. Furthermore, awareness of its potential value may encourage psychiatrists to use their considerable community influence to support its development and extension.

The material for the paper is derived from my experience over several years as psychiatric consultant for the Minneapolis Family and Children's Service, as participant in its training program for homemakers, and in collaborative work with the agency in a few cases where a mother of young children was my patient. My illustrations are drawn from the records of 16 cases which were presented at consultation seminars during a four-year interval, and which were selected from over 100 cases in which the agency participated in that period.

Six Requirements Noted

Homemaker service is indicated for families in which the mother of young or adolescent children is mentally ill under the following six conditions:

1. *The father or other responsible adult is living in the home.* This requirement is essential since it is impractical for social agencies to take full responsibility for families. Furthermore, the goal of homemaker service is the maintenance or reconstitution of the family; one of its major advantages over foster home placement lies in the fact that the father is kept in close contact with his children during the period of disruption caused by the mother's illness. His home and his children sustain him in his deprivation and may give him the support necessary for him to maintain the integrity of the home, which in turn makes it possible for the mother to return to familiar surroundings for her convalescence.

2. *The illness appears to be temporary.* Although the accepted limits of homemaker care have increased from a few weeks to a year or more, most agencies cannot yet undertake indefinite care. If it appears unlikely that the mother will ever return, an alternate plan, tailored to the specific needs and resources of the family, may be necessary. Often the agency may help the family work towards the development of a suitable permanent plan, meanwhile providing temporary homemaker service to allow enough time for the details to be worked out. A temporary solution without radical change in the family structure can protect the father from taking immediate steps out of desperation, steps which may damage the security of the family or in other ways prove unsatisfactory.

3. *The family participates in casework.* In homemaker service, as

contrasted to housekeeping service, the agency takes casework responsibility for the welfare of the children and hence must maintain contact with adult members of the family as well as with the homemaker. The homemaker's primary responsibility is child care rather than housework. Since she does not have professional training she relies on the caseworker for much of her understanding of the specific problems of children deprived of their mothers. To give adequate guidance the caseworker must know the details of the family situation. The caseworker also clarifies the homemaker's function to the father, and in so doing helps him to maintain his role in the family. In regular contacts with the father, she may also be able to help him understand some of his own feelings concerning his wife's illness. Casework participation may forestall the tendency of some fathers to delegate all parental functions to the homemaker, and the tendency of others to limit the homemaker to housework and menial duties.

Casework may be even more important with the mother during her convalescence, as illustrated by the following abstract of a record of casework interviews with Mrs. P, a convalescent patient, concerning her relationship with Mrs. H, the homemaker:

> For the first two weeks Mrs. P was home from the state hospital she seemed very happy with homemaker service. She then began to feel guilty because she needed a homemaker, and later complained that the homemaker's ability to handle the work and care for the children implied criticism, and seemed to emphasize her own inferiority as a mother. Later Mrs. P admitted her jealousy of the place Mrs. H had with the children. Mrs. P also said that Mrs. H seemed like a mother to her. She recognizes that a good deal of her reaction to Mrs. H is a reliving of her relationship to her own mother. Mrs. P also says that when she is feeling depressed she likes to be alone and doesn't want someone constantly in the house.
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> From Mrs. H's description of Mrs. P's depressed days, Mrs. P apparently withdraws from the reality around her and seems almost in a "trance," not seeing the children and not carrying out her household work. Mrs. P frequently has asked whether having someone one or two days a week wouldn't be enough. For one week we did have Mrs. H go in for three days, but Mrs. P seemed frightened at the evidence that her idea of reduced service might be accepted. Although she feels she should manage alone, she has a strong conviction that she is unable to. In my discussions around this, I have tried to help Mrs. P look at her resentment of the homemaker as acceptable and natural. I have tried to help her justify having service in order to give her more opportunity to get well. Much of this Mrs. P can understand on an intellectual level, but she continues to struggle with it emotionally. On one occasion she mentioned "giving" the two youngest children to her sister since she could

> never be an adequate mother, and on another occasion she was so sure that she was bad for her family that she talked of getting herself recommitted to the state hospital to give her family a chance to escape her.

Through the agency, the state hospital follow-up clinic was kept informed of progress and problems in this patient's convalescence.

4. *The mother is in the hospital or convalescing at home, but does not require psychiatric nursing care or supervision.* Homemakers are not trained in nursing; their primary orientation is toward child care, and they cannot undertake supervision of confused or suicidal patients. Furthermore, since the homemaker's role with a convalescent mother requires unusual tact, flexibility and understanding, an agency may not always be able to provide individuals who can adapt to the situation.

5. *The agency and the psychiatrist with responsibility for the patient's treatment maintain lines of communication.* On application for homemaker service, the family is customarily asked to sign a release of medical information. Without medical information, the agency cannot properly determine the applicability of its services, and will probably withdraw from a case where medical information is not made available.

This is particularly important when the mother is convalescing at home. Often such a patient will confide in the homemaker or the caseworker. She may reveal the first evidences of relapse, or suicidal preoccupations, or dissatisfactions with treatment to the homemaker. The psychiatrist therefore should keep posted on the homemaker's observations.

> One homemaker reported: "When the eight-year-old boy was leaving for a weekend trip to his grandmother's, I heard his mother say: 'Go ahead and leave me. I'll get well while you're gone. It's you who makes me ill. You are deliberately driving me into my grave.'" The homemaker, although distressed at this incident, did not attempt to interfere with the interchange, but informed the caseworker by phone after she left the patient's home. The caseworker used this and other similar evidence in a later discussion with the psychiatrist and the patient's husband, which led to the patient's rehospitalization.

When communication is easy between psychiatrist and agency, the psychiatrist has an opportunity to suggest appropriate attitudes and measures for the homemaker to adopt. Although the milieu cannot be regulated as thoroughly as in a hospital, the caseworker passes on and interprets the psychiatrist's suggestions to the homemaker, who usually can carry them out more objectively than can either a relative or the customary type of domestic help. The psychiatrist can arrange to receive progress reports from the caseworker at regular intervals by telephone or mail.

6. *The total family plan involving homemaker service is realistic.* The following case illustrates some of the factors leading to the agency's decision that homemaker service could not be provided:

> Dr. X advised Mrs. Y, a mother of three small children, to enter a private psychiatric hospital. Mr. Y was a college student who worked evenings in a bowling alley to support his family. Their income was $200 a month. Mr. and Mrs. Y were residents of a neighboring state, and ineligible for local hospital care except in private facilities. Mr. Y's hospitalization insurance would cover no more than a small fraction of the hospital bills. The children needed care in the evenings when their father worked, requiring a homemaker to return home late at night with poor public transportation. (Most homemaker services can supply only daytime care.) Although Mr. Y stated that his wife would be much more upset if the home were broken up or if they returned to their home state, the agency did not believe it realistic to institute homemaker service.

Service Is Evaluated

As with other aids to rehabilitation, it is virtually impossible to demonstrate the results of this program in clear-cut or unequivocal terms. So many factors enter into each individual situation that no adequate controls can be established, and recourse must be taken to anecdotal evidence.

Thus homemaker service appeared to alleviate the tensions in all three of the families mentioned in the first part of this paper. Six-year-old Cheryl, who thought she was naughty and wished she could go to heaven, became much more relaxed and began to take an interest in school and her friends. In the second case, Mrs. C's 12-year-old daughter, relieved by the homemaker of the responsibility of the home, could resume her little girl relationship to her father and avoid the tension associated with the role of substitute wife. The children in the third example, who had oscillated between their own and a foster home, could remain at home, even though their mother continued to have periods of exacerbation and remission. Protected by the homemaker's calm and balanced attitude, they were better able to overlook their mother's peculiarities and give her the encouragement of their support in her eventual convalescence.

Direct and indirect observations of the effects on children, on fathers, and on the patients lead me to believe that homemaker service can make a substantial contribution which cannot be duplicated by any other existing service for any group in our society. In most agencies, therefore, homemaker care is not restricted to the indigent. Agencies with fee-for-service programs provide homemaker care for any income group, scaling the fee to the income of the patient's family. The following case is typical:

> When the mother of three small children required sanitarium care for depression, the psychiatrist recommended homemaker care. The father, a well-to-do executive, could easily have hired a housekeeper through an employment agency. He recognized, however, that a home-

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maker was better for the children than a housekeeper who did not have the advantages of contact with casework services, or than a somewhat controlling grandmother whose presence in the house would have been a serious threat to the mother. After a few weeks, the mother returned from the hospital, then relapsed, and later came home again. Meanwhile, the homemaker, bulwarked by the agency, gave consistent support both to the father and to the children through the periods of transition. She made it possible for the rest of the family to give security to each other during the mother's illness, and for the mother to return to a familiar and organized environment during her remissions.

In summary, homemaker service contributes substantially to the rehabilitation of mothers of young or adolescent children who require, may require, or have required psychiatric hospital care. It also contributes substantially to preventive psychiatry through decreasing the insecurity and anxiety of the children involved. The development of homemaker services can be materially assisted by the influence of psychiatrists in their communities.

Homemaker Services for the Aged and Chronically Ill*

by Brahna Trager
Executive Director
San Francisco Homemaker Service

When we hear homemaker service described as a resource for chronically ill and aged individuals we most often find that it is presented or "sold" to the community for one or a combination of the following reasons:

First, that it will prevent institutional care;

Second, that people are "happier" in their own homes;

Third, that it is a way of keeping elderly people with their families;

Fourth, that it is cheaper than institutional care.

Some of these reasons are valid or, at least, hold in certain circumstances. Some of them are not valid at all. At the risk of discouraging some of you, but in the hope that we will all feel more secure with realistic objectives, I should like to talk about both the dangers and the values of homemaker service for the chronically ill and aged.

**Paper given at Minnesota Welfare Association Annual Conference, March 15, 1965.*

When I looked at the program describing this paper, I noticed that reference was made to "two groups of people" and I realized that the reference was to the "aged and chronically ill" and that, by inference, these two groups had been considered separately in connection with the development of a homemaker program. This is a very understandable assumption to make and it is one with which I am very familiar. Most people, when they think of homemaker service for adults, tend to make this distinction in their minds. That is, they consider aging as a separate entity and chronic illness as a separate entity. The important point which needs to be understood, however, is that age alone does not make assistance from a homemaker service a necessity. It is chronic illness that creates the need. People who are perfectly well do not need homemaker service, and many older people are perfectly well. As a matter of fact, an adult homemaker service does cover a rather wide variety of situations, ranging from the young or middle-aged adult with a chronic disease or physical handicap which impairs normal functioning to the very fragile, aged person with multiple disabilities who is unable to manage at home without some kind of assistance.

No Situation Is Static

One of the things I should like to emphasize, however, is that the development of services for the total group, young or old, should take into account one very important fact. That fact is that in chronic illness no situation is static. Whether we are looking at a chair-bound polio patient in her 30's, a multiple sclerosis patient in her 40's, a cardiac patient in her 50's or an 80-year-old patient with a multiplicity of difficulties which make up the problems requiring assistance in the home, there may be hours, weeks or even months when things seem to be going very well and when one might almost feel optimistic about discontinuing service. But there will be periods—and sometimes long periods—when constant changes in the patient's status will mean that a variety of services in a variety of combinations and in different concentrations will be necessary. And this is where the most important part—that of community planning—comes in.

In terms of need, a chronically ill person may require institutional care for part of the time; for part of the time he may be able to be at home, but with a range of services available to him, such as those provided through an organized home care program with daily medical visits, physical therapy, occupational therapy and bedside nursing. Some of the time the need for such services will diminish and what will be required is simply a homemaker to come in and maintain a decent environment, do some shopping, cooking and laundry. Some of the time this is in combination with bedside nursing, and some of the time it may be a matter of some homemaking service with some personal care added, and by personal care I mean that the individual may manage perfectly well, provided someone can come in to help with such things as dressing and bathing in addition to the major physical tasks of maintaining the household.

If, then, we have a situation which is constantly changing as far as the needs of the patient are concerned, it is not possible to say that a homemaker service provides the simple solution. One of the most important elements of a program for the chronically ill and aged thus revolves around the availability and coordination of services in order to provide the appropriate service at the proper time.

The necessary resources will include medical care, sources of economic assistance, nursing services, and such specialized social services as may be needed. But whether they exist in full supply or are minimal, good use cannot be made of them unless there is an approach to the conception that a continuum of care involves an acceptance of responsibility for the family or the individual as he moves through the various levels of his need. And here I think I should like to say that without this approach, homemaker service for the aged and chronically ill is virtually useless. There is no question that it can be a powerful sustaining service for the patient at home, but it cannot operate in a vacuum and it cannot manufacture the necessary services which are essential in good planning. And in planning, coordination is essential.

Often when we discuss this important question of coordination we are told that this is the responsibility of the private physician. I think we must realize that although, in the optimum situation, the private physician knows his patient and knows the needs of his patient, it is probably unrealistic to expect him to function as an agency would function since, as an individual, he is unable really to tap community resources and to maintain services for his patient in a coordinated way.

Agreement on Planning Must Be Reached

There is another assumption, of course, which is commonly made and that is that each agency which carries the case will be responsible for this kind of planning and coordination. This is a possibility, provided that there is a clear understanding in the community about where one agency's functions begin and another's leave off. In other words, problems of overlapping and problems of duplication will have been explored and some agreement made about the on-going responsibility for the planning of long-term service, regardless of where the service itself may come from.

In our experience after several years, we found that one of the major difficulties which the chronically ill patient at home had to face was the fact that since he is in a sense invisible, he can be easily forgotten. Patients in a hospital bed must be looked after. The patient at home, whose need for a specific service has terminated and who may later need something else, does not automatically receive the necessary assistance, but usually comes to someone's attention in another crisis situation which might have been avoided. We found that sometimes when we closed a case to homemaker service because it really seemed that we were no longer needed, a whole new set of needs developed over a period of weeks or several months and, by the time we were brought back into the picture (if we were), institutional care was the only solution. Often it was a solution that could have been averted.

In our community, we began to look for a way to avoid fragmentation and to provide the kind of continuity of supervision (or at least the continuity of concern) which took into account this changing status in the chronic disease patient. We have established a demonstration program in part of the community in cooperation with our public health department. To us, the health department seemed to be the agency with the best potential to serve this group. First of all, it has a community-wide responsibility; second, it is health-oriented and has available on its staff medical officers, public health nurses and nutritionists, and provides services which can be utilized on a consultation basis. Third, it is not means-test oriented and its major concern is the maintenance of positive health. Fourth, it has a field service pattern—that is, it does have a staff of public health nurses in the field who are committed to visiting people at home.

There is no question in our minds that this approach serves the chronically ill patient far better than any individual agency could, and in that respect we feel that we really do have a splendid example of what a well-organized service can provide. Here again we consider that homemaker service is only one of the important services. Often, however, it is the basic, sustaining service. The homemaker, who sees the family far more often than anyone else does and in the most intimate circumstances, can provide the basic information about what is going on so that intelligent planning becomes possible and, if we agree that change is one of the basic factors in chronic illness, the addition of the homemaker is important far beyond the seeming simplicity of her services.

I should not like it to be assumed, however, that, even with well organized and coordinated programs, institutional care for the chronically ill can be eliminated. Homemaker service does not take the place of institutional care. It is dangerous, it seems to me, to pretend that it does. An individual who needs round-the-clock nursing supervision or at least round-the-clock nursing surveillance, who must have ready access to medical care, laboratory facilities and other medical aids, whose mobility is so limited that bed care and physical help with most of the activities of daily living are necessary, usually belongs in an institution. I know that it is possible to bring to such individuals the resources of organized home care services, but where such a combination of circumstances as I have described exists over a long period of time, the development of a program at home is extremely difficult and, what is more to the point, it isn't safe.

Those of us who are giving homemaker service to the chronically ill and aged at home are, at times, profoundly indignant because we are expected to maintain patients in situations which are degrading and impossible on the theory that the patient is "better off" or "happier" at home. We no longer tolerate the county "pest house" to which we used to relegate our dependent, discarded citizens and yet it is most surprising to see with what equanimity we allow very sick people to remain in rat-infested tenement rooms without heat, with shared bathroom facilities which they cannot reach because of physical limitations, with shared cooking facilities or hot plates and with no possibility of obtaining adequate nourishment; with no access to the out-of-doors, often without telephones, but always with that grim loneliness that comes from the knowledge that, whatever terrors arise in the way of pain and sickness, they must be borne. We would not tolerate such circumstances in our institutions.

The development of in-home services programs, such as homemaker service and organized home care have, as their component, the dangerous possibility that such situations can occur and continue while the community, all the while, is comfortable with the generous and reassuring idea that it is caring for people in their own homes and that they are "happier in familiar surroundings."

It Is Not Necessarily Cheaper

I should like also, at this point, to explode another myth, and that is the myth that it is cheaper to maintain a chronically ill or aged person at home than in an institution. This is not so at all. Bad care in any situation, of course, is cheaper than good care and, when I spoke of the dangerous situations which are the result of ignorance or indifference on the part of the community I was, of course, talking about cheap care. It is much cheaper to allow someone to slowly deteriorate at home than it is to give even the minimal kind of domicilliary care in an institution. If, however, we take into consideration all of the costs of a constructive in-home services program we are not dealing with a minimum cost program. What I would prefer to have all of us use in discussing a homemaker program for the chronically ill and aged today is the standard that we would like to do what is better rather than what is cheaper.

In order to plan such a program—one that is really a constructive homemaker program—the nature of the need must be understood. I'm going to be talking today about a predominantly urban situation, although many of the principals developed here would apply equally, I should think, in any circumstance. We do know, of course, that the urban area is the center, usually, of the aging population. In our community, for example, eight years ago about nine per cent of our population was over the age of 65. Today, about 13 per cent of our population is in this group. This means that we are confronted with an increasing number of individuals who are going to be moving into the orbit of any in-home services program that is developed. Thus, as we look at the homemaker service geared to the chronically ill and aging in an urban community, we must recognize first that volume will be one of the factors we would have to consider in our planning. With respect to volume, of course, all of us have heard repeatedly that it is difficult to provide service in volume that is also of high quality.

Another characteristic of this group is that almost invariably illness will be the primary problem at the point of referral and illness will usually be chronic. This means that in an agency which is really interested in the adult chronically ill no foreseeable termination date for service can be established. For example, in a caseload of approximately 500 families in 1964, with a medium age of 73, and with approximately 20 per cent over the age of 80, about 210 families had been carried over in our service from the previous year. About a quarter of these families have been in service for about three years and we do have a group of families who have been receiving service off and on for a period of about five years.

With respect to staffing, one of the great difficulties that we had in the beginning of our program was in recruiting social workers to act as supervisors for our homemakers. Despite the fact that aging is very much in the forefront today, social workers have repeatedly told me that they preferred to work with children and young adults. They see the older age group as having no potentials, and they see service to this group as rather a depressing one and without professional stimulation.

It has been very interesting to see the change in our professional staff over the years. They have come to realize that there is no point at which a person becomes "old." Except in those situations where there is personality deterioration as a result of illness, there is just as much to interest a good social worker in a 73 or 80 or 85-year-old individual as there is in a 7-year-old or 18-year-old, or 30-year-old individual. There is the same variety in relationships, sometimes made more interesting by a lifetime of experiences which have been appreciated. There are the same abilities to learn, to grow, to appreciate pleasure, to respond to pain. There is indeed in this group, perhaps more than in any other, a kind of striking fortitude—sometimes in the face of overwhelming adversity—which our staff says makes one think of aging very differently.

Field of Aging Is Beset by Clichés

I think that in the field of aging we are more beset by clichés than in almost any other group. We think either of a sad, senile, aged person for whom nothing can be done, or we think of the sentimentalized picture of the white-haired lady in a shawl or the white-haired gentleman in a rocking chair who must be treated gently, but with a kind of stereotyped approach that has nothing to do with our usual patterns of approaching the individual as an individual. I am always interested to see our young workers gradually lose this sense of the stereotype and begin to work with families in this age group in very much the same way as they would with any other, evaluating strengths and weaknesses, working with relationship patterns and even, quite successfully, modifying those that mitigate against using the environment, using life itself in the way in which social workers are always helping people to use what is there for them.

In this age group we are not, as a rule, "keeping the family together," since about two-thirds of these people are alone; the rest usually are living with equally disabled family members. But there is, and there must be, in order for us to maintain a home service plan, a strong desire to be at home, along with physical safety and a reasonable environment. We feel that it is essential that medical supervision be available, and by medical supervision we really mean that our agency and the patient must have access to a physician who will respond to the medical needs of the family. This, I might say, is often one of the most difficult things to manage and it is one in which homemaker service alone cannot be effective. Here again the community has a real responsibility. We prefer not to have the kind of medical supervision which is crisis-oriented. We hope for a physician who is interested in following the patient and in helping us to maintain an optimum state of health, and we try at the outset to make this very clear. We want, for example, to know just what kind of regime is necessary; we want to know how much activity is desirable, what kind of special diet is needed and whether other services should be brought to the family. These other services, of course, include bedside nursing and nursing supervision, and occasionally it is possible for us to bring, through resources of other agencies in the community, physical and occupational therapy into the home. Where we accept a patient at the point of discharge from a hospital or institution, we try to obtain assurance that in an emergency, or if the situation warrants, institutionalization will be possible.

We usually define homemaker service as a professionally supervised service in which mature and capable women are sent into the home to maintain it in situations in which illness, the absence of the person usually responsible, or some other family crisis occurs which makes this kind of assistance necessary. Whether the professional supervision comes from a nursing agency or a social agency will, of course, depend on the population which the agency plans to serve. However, it has become increasingly evident that in those situations where there is illness, where social disruption has occurred, where there are crises, regardless of the initial problem, both nursing and social work will necessarily collaborate in the provision of or planning for homemaker service. Most nursing organizations either utilize the services of a social agency or employ their own social workers, and most social agencies are finding that the services of the visiting nurse or the public health nurse are almost invariably essential.

The sensitivity and skill of the professional, who first sees the situation and who begins to attempt to foresee the "what will happen" or "what may happen" or "what should not happen," are major factors in the provision of good service. I am convinced that there is probably no responsibility which requires more of the professional person than this one of providing an on-going day-to-day service intimately bound up with the life of a family at a time, usually, when crisis is the order of the day and when problems are often seemingly insurmountable.

Recruiting Requires Great Skill

The professional, of course, exercises the highest level of her skill when she recruits a homemaker. It is not easy to accept an outsider in the home when things are difficult, no matter how necessary that outsider may be, and what we look for initially is a kind of general attitude—something in the personality which gives at least some assurance that this is a human being who comes with warmth and tolerance to be of help. Although many agencies do require a certain educational level in their homemakers, we do not, in our agency. We look for other things. What we hope to find, and often do, is an attitude of acceptance, of humor and what I can only describe as the absence of "touchiness." We explain to our women that they will be expected to maintain an even disposition in situations where others may be very irritable and very critical, that they may be expected to exhibit a kind of calm, good cheer in situations where frightening depression and even more frightening illness may be present. We look also for a kind of appetite which is not so much a compelling desire for cleanliness as pleasure in the provision of food, services and a serene environment, with the only reward being the creation of that atmosphere. It is surprising how many women we have found who meet these criteria and once we have found them we commit ourselves to a program of on-going partnership.

In all of our contacts with the homemaker, we try to build in her the kind of security that makes it possible for her to confide in us about any unusual difficulty or discomfort that she may have in relation to her work or to the families she serves. We make it very clear that we expect her to come to us with these confidences and that her job is not at stake. We have a long tolerance for errors and our homemakers soon realize this. They know that if they find a situation intolerable, they can ask to be taken out of that particular situation and that their position in the agency would be jeopardized only if there were more intolerable situations than those that were tolerable, in which case we will make an effort to find them private employment. We assure them that the fact that a family asks to have them removed does not mean that they are not good homemakers but simply that people are different and that, while they may be unwelcome in one home, they will undoubtedly be very welcome in another and this usually proves to be the case. They accept with equanimity the changes that are made either because a family has no other outlet than to be dissatisfied with the homemaker, a situation which they usually view with sympathy, or because a different kind of service is now necessary, a situation which they come to understand professionally.

Trained to Be Good Observers

Above all, we train them to be good observers and we let them know when their observations have been the most helpful to us and we sometimes share with them our own difficulties in helping to work out a family situation, with the very frequent result that practical suggestions are forthcoming which are extremely helpful. This is not surprising since we have come to respect these women very much and know that their contributions often make the difference between sound planning and something less than adequate. I do not think that this is unique with our agency. I have never been to a national conference of homemaker services that I did not hear other professional staff refer to their homemakers with the same kind of warmth, affection and respect that we have for ours.

I think it would be inappropriate to talk so glowingly about homemaker service without spending a little time on costs. I said earlier that homemaker service is not cheaper than institutional care and I would like to amplify that now. First of all, where the total resources of the community are organized around in-home service plans, all of these costs must, of course, be included in the cost of providing service at home. So must the cost of maintaining that home. Frequently, when people try to make comparisons, they will add up the homemaker bill for the month and then ask what the cost would be of maintaining a person in an institution and there is, of course, a sharp difference. But we must remember that the institution computes its total cost and that the bill for the homemaker's hours is not the total cost of maintaining a patient at home. Homemaker service of the quality that I have just described is not in itself inexpensive. We pay our homemakers a premium wage and they are entitled to the same benefits as any other staff member. This, added to the cost of good supervision, means that the community must pay a good price for a good service.

Section III

Standards for Homemaker-Home Health Aide Service

As a new and rapidly growing community service, homemaker service programs had few formalized guides as reference points in the decades of the 30's, 40's and 50's. Therefore, when the National Council for Homemaker Services evolved from the National Committee on Homemaker Service in the early 60's, a major goal was the formulation of standards for the homemaker field. This was no simple task in view of the major interconnections which homemaker service necessarily has with the two related but differing fields of social services and health services. The complex but successful process which was used is described in the foreword to the STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, published by the Council in 1965. The foreword and other material selected from this publication form the framework for this section.

A source of standards for homemaker service for children has been the Child Welfare League of America which issued a statement of standards in this area in 1959 as part of its Standards Projects for the several fields of child welfare. The statement defines homemaker service as a child welfare service, specifies its objectives and purposes, and describes those children for whom it is appropriate. The statement is included in the present section.

The U.S. Department of Health, Education, and Welfare has established guides for the implementation of homemaker service within public assistance programs. These guides, defining the service and the role of the state and local public welfare agency, are reprinted here.

One of the aspects of homemaker-home health aide service which has been of increasing concern is the definition of the nature and extent of personal care which is to be given by a home health aide. This concern led to the convening of a conference of representatives of the principal concerned groups, including agencies with homemaker service programs, nursing organizations, the American Medical Association, American Heart Association, American Cancer Society, The National Foundation, and American Public Health Association. This group, meeting at Arden House in 1960, issued a statement concerning personal care and formulated guidelines regarding the homemaker's role in this area, both of which are presented in this section.

Standards Developed by National Council for Homemaker Services*

(This and the following six summary statements are reprinted from STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES)

Foreword: The Code, Content and Council

The development of the Code of Standards for Homemaker-Home Health Aide Services has been a major undertaking of the National Council for Homemaker Services. The principles set forth in it result from research on current practices in the homemaker-home health aide field; a majority of appropriate agencies throughout the United States have contributed to this research. Representatives of 17 national welfare and health agencies, chaired by an outstanding authority on homemaker programs, have worked as a Committee on Standards for the Code from September 1964 through June 1965. They have had valuable consultation from representatives of three Divisions of the U.S. Department of Health, Education, and Welfare: the Children's Bureau in the Welfare Administration, the Division of Chronic Diseases in the Public Health Service and the Community Research and Services Branch in the National Institute of Mental Health.

The Committee on Standards, during the fall of 1964, selected certain topics considered basic to the Code and outlined particulars related to them. Thirty additional individuals, knowledgeable on homemaker-home health aide programs, joined the Committee on Standards in early 1965 to provide further consideration of necessary Code content. A three-day workshop, to clarify and establish valid principles for the Code, was held at Princeton, New Jersey, in mid-March.

It is believed by the Committee that the principles included in the Code are applicable to all homemaker-home health aide agencies. They are valid for autonomous agencies or programs set up under voluntary or tax supported "host" agencies; they are applicable to a beginning or small homemaker-home health aide program and to the large agency with many professional employees and homemaker-home health aides. The Committee has, therefore, provided standards for the establishment of new homemaker-home health aide services and the expanding and improving, where necessary, of older programs. These standards will be minimum for certain agencies; they will offer goals to work toward for others. They set forth general principles which may have to be adapted either because of agency structure or local or state laws.

Excerpts from STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, published by National Council for Homemaker Services, 1965.

The National Council for Homemaker Services and the Committee on Standards appreciate the practical assistance given toward the development of the Code by the Department of Health, Education, and Welfare. Only because a three-way contract was drawn up by the Bureau of Family Services and the Children's Bureau in the Welfare Administration, the Division of Chronic Diseases in the Public Health Service and the National Council for Homemaker Services has it been possible to finance the production of the Code. The Code represents a worthwhile collaboration between Federal agencies and a voluntary national organization.

Purpose and Function

Homemaker service exists to maintain, strengthen and safeguard family life. It is provided by a tax-supported public agency or a voluntary non-profit community agency; the homemakers performing under agency aegis are qualified and trained; and are selected, assigned and supervised by the professional staff of the agency. Children and adults with various medical and social diagnoses benefit through homemaker service.

Originally organized to serve children, it has broadened its scope to include many economically, physically and emotionally disadvantaged groups of both children and adults. The help given to an individual living alone or to a family group may differ according to the need of the individual or the family group. The professional staff of the agency, therefore, continually evaluates the service plan and determines its on-going suitability.

Provision of Homemaker Service to Individuals and Families

Referrals to a homemaker program may come from within its own agency or from a broader spectrum of community sources. At the point of referral, the professional staff is responsible for accepting or rejecting the application. In order to do this effectively, the agency must establish criteria of eligibility for its service. If an application is accepted, a service plan to fit the special need should be developed, including individual payment arrangements, however the payment is met. There should be flexibility in regard to the provision of the service. The evaluation and supervision of the home situation by a social caseworker with special knowledge of child care practices and treatment should be included when homemaker services are offered to children. Personal care practices of homemaker agencies should be established and reviewed by appropriate regulatory standard setting bodies. Both social case work and public health nursing should be included where, among other services, personal care is provided for a patient.

Organization and Administration

Every homemaker service, whatever its auspices, must have a governing body responsible for its total operation. Responsibilities should include establishment of the legal status of the agency, appointment of subcommittees, adequate financing of the program, selection of the executive, establishment of the scope of the program and development of the procedures. The governing body should approve criteria for selection of various members of the staff, including homemakers, and for personnel policies which will result in satisfactory performance of job assignments at all staff levels.

Staffing of a Homemaker Service

Whether the agency is small or large, three functions are necessary for its operation, i.e., executive, supervisory and direct service provided by professional staff and homemakers. All three functions may be performed in a small program by one staff person and a limited number of homemakers. Principles outlined in this chapter, however, should allow for satisfactory staff performance in any size agency with any number of staff. Special emphasis is placed on the program enrichment possible through the imaginative and broad inclusion of consultants and volunteers. It is also suggested that in certain situations auxiliary personnel should be employed by the agency to supplement the work of the homemakers.

Orientation and On-Going Education in a Homemaker Program

Every individual associated with a homemaker program should have comprehensive knowledge of its purpose, function and objectives. This will be achieved if there is effective orientation, basic and on-going education provided for members of the governing body and all staff.

Homemakers should have a carefully planned training course before assignments to jobs. They should be given opportunities for continued learning through on-the-job teaching and professional supervision.

Records

The homemaker agency, from its very beginning, must maintain adequate records on all aspects of its program. The executive has a responsibility to plan the record program and staff members at all levels of operation are obligated to contribute statistics related to their individual job assignments. Records should be maintained on four areas of agency operation, i.e., intake, service, personnel, and finance, including cost accounting. Data to be obtained through the four above record classifications should provide sufficient information to allow for an adequate picture of the agency's program and operation — both service and fiscal.

Community Relations

The homemaker agency is dependent on various sections of the community for the success of its program. It should, therefore, establish itself from the beginning as an integral part of the local system of public and voluntary welfare and health services. To this end, it should maintain broad relationships at the direct service level. It should participate actively in interpreting and promoting the interests of its own program and of the homemaker field. It should also call attention to, and offset where possible, deficits in community service which prevent its optimum help to people. Agreements with cooperating agencies should be clear and kept up-to-date. Volunteers should be involved extensively in the agency's program. All channels of communication should be utilized to interpret the program and needs of the agency and the importance of homemaker service to the community.

Homemaker Service as a Child Welfare Service*

Homemaker service, when offered as a child welfare service, is one of the social services which the community provides to make it possible for children to receive in their own homes the care they may lack when circumstances impair or interrupt the ability of their parents to carry out fully parental responsibilities.

1. Elements of Homemaker Service

The distinctive elements of homemaker service are: (a) placement in the home of a trained homemaker employed as an agency staff member, who works together with a caseworker in carrying out a casework plan to help restore and strengthen parental functioning, or otherwise assure that the child has the care he needs; and (b) use of casework as an integral part of the service

- in determining whether the children's needs can best be met through homemaker service, by some other service, or through the family's own resources
- in helping the family to make constructive use of the total service and of the homemaker particularly
- in preparation and guidance of the homemaker in individual family situations
- in helping the parents, and the children where indicated, to maintain or regain their equilibrium, and to cope with problems that may be

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economic, medical, social, emotional or a combination of these

- in coordinating various services, such as medical, psychiatric and financial assistance, that may be involved in helping the family.

2. Objectives and Purpose

The ultimate objective of homemaker service for children is to promote healthy personality growth and the development of their individual potentialities. Its immediate purpose is to enable the child who might otherwise lack the care he needs to remain with his parents so long as they are capable of providing suitable care or can be helped to do so.

Homemaker service should help parents to carry out their responsibilities for their children as fully as they can; and to deal more adequately with their problems.

For the child, including those with physical, mental or emotional handicaps, it should help

- to prevent severance of parental relationship, and damage to personality through deprivation of parental care
- to safeguard him against emotional or physical neglect under circumstances or during periods when his parents' ability to give care is impaired
- to preserve his security in the familiar surroundings of his own home, school and neighborhood
- to avoid emergency removals from his own home, boarding home, or family to which he belongs
- to reduce the use of shelter care, or emergency and preliminary placements.

3. Children for Whom Homemaker Service Is Appropriate

Homemaker service should be considered for children who are lacking or may be deprived of love and proper care because of family circumstances or problems of the parents, and whose individual needs can best be met in their own homes. These include:

- children whose mother is absent from the home for brief, indeterminate or prolonged periods due to physical or mental illness, confinement, desertion, divorce or death
- children whose mother is in the home but unable to perform all her mothering functions because of physical or mental illness, disabilities, convalescence, residuals of illness, or complications of pregnancy
- children in families where the mother is worried and preoccupied with the care of the father, another child or another member of the family such as a grandparent who is chronically ill, convalescing or permanently disabled through accident or disease; or where a mother

has a prolonged grief reaction over the death of the father

- children whose mother does not know how to care for them or how to keep house, due to lack of preparation or training, low intelligence, emotional immaturity, her own deprivations, or overwhelming responsibilities for many children, but has a relationship with them which has value for them
- children whose mother has to be employed during the day for an interim or indeterminate period, because of economic necessity, or at times because of emotional disturbances in spite of which she can be a good parent if she has some financial responsibility and outside interests; for whom a housekeeper plan or day care service may be arranged later, or for whom group or family day care is unsuitable because of their age or special needs, or is unavailable
- children living in foster families and boarding homes, or with a grandparent or some other relative who is close to them, when problems arise which might require placement in another home
- children receiving specialized psychiatric treatment or treatment for serious physical ailment such as a heart or eye condition, who need special care by the mother which she can give only with some relief from her regular duties and the care of other children in the family; who may require care from a homemaker while parents are receiving casework or psychiatric help with problems that make it impossible for them to cope with the child or tolerate his behavior; or whose treatment can be facilitated through observation of the child's intimate living experiences to aid the psychiatrist or the physician in understanding the child
- children for whom an alternative plan, such as placement, has to be developed, and for whom a diagnostic study and/or preparation for placement may be required.

4. Conditions for Choice of Homemaker Service

Homemaker service should be selected as an appropriate service under specified conditions:

a. The child can benefit from remaining in the home, even with one parent, a grandparent, another relative or a foster parent, because there are potential strengths and healthy relationships in the home on which to build for the child; the parents have the capacity, with support, to function as parents; and the quality of the relationship between parent and child is such that it has positive values for the child.

b. Parents can keep the children in the home and maintain family relationships only with the help of an outside resource such as a social agency.

c. At least one parent will be able to carry the additional responsibility placed on him, when the other is ill or absent, for providing the care the child needs, or a responsible adult will be available to participate in planning and to share responsibilities for the care of the children with the homemaker. This should not, however, preclude consideration of homemaker service on a 24-hour basis during a period of crisis where both parents may be out of the home temporarily, as in the case of accidents, and where it may be preferable for the children to remain together in their own home rather than to move into strange surroundings.

d. The family will be able to accept and use the service, and through it will be able to give the care necessary for the physical, mental, emotional and spiritual growth of the child, and to solve or ameliorate the basic problems.

e. Physical facilities should be reasonably suitable for giving children the care they need. If not, and if it is important for the child to remain in a home even though its physical standards are substandard, it should be possible to provide financial assistance, household equipment and clothing to meet basic needs, either as part of the service or from some other source.

5. Eligibility Requirements

Neither income nor length of time for which the service may be required should determine eligibility for homemaker service.

a. The financial status of the family should not be a condition for providing or withholding homemaker service if it is appropriate in meeting the needs of the children. The family may need financial assistance, or may be able to pay full or partial cost of the service.

b. The probable duration of need for the service, the number of days per week or hours during the day or night should not be determining factors in the use of homemaker service. The service should be made available for short-time and emergency needs or extended periods, day or night, until the parents can care for the children without help, or a more suitable plan is arranged.

6. Alternative Plans

When conditions in the home and the quality of the child's relationship with the parents are such that his own family cannot, even with help, provide the essentials for his well-being, the child should be given the opportunity of having a substitute family life experience or group care, in accordance with his needs.

Homemaker-Home Health Aide Services in Public Assistance Programs*

Homemaker service provides, through a team of agency staff, certain in-home services to help maintain and strengthen family life and safeguard the care of children and the functioning of dependent adults—physically or emotionally ill, handicapped or aged persons—in their own homes when no responsible person is available for this purpose. Agency social work staff establishes with applicants their need for the service on the basis of social and, when indicated, medical evaluation and recommendation; develops a suitable plan, with other professional persons as needed, for providing the service for short periods or on a continuing basis, full-time or for only a few hours at stated intervals; assigns and supervises the homemakers and continuously evaluates whether the service provided meets the need of its clients; and plans with the client, the homemaker, and other professional persons for changes or termination of homemaker service and for alternate care of the client when necessary.

Homemaker service is an organized agency service related to agency program goals, as are all other services. It differs from domestic service in several significant respects. Homemakers are employed agency staff—trained, directed and supervised by professional personnel, as are all other agency staff. They carry specific and fuller responsibility for child and adult care, training in home management, and for household and money management, than is ordinarily expected of household workers and the agency is ultimately accountable to the client and to the community for the quality of service provided by the homemaker. They are responsible to the agency, which is in turn responsible for the quality of service, for its continuity and appropriate use. Therefore, arrangements made by the agency or by the client himself for him to secure a household worker to work under the client's direction and be paid by the client, do not constitute homemaker service. Such arrangements involve the usual employer-employee relationships.

Homemaker service does not result merely from the assignment of a homemaker to a family or individual situation. It derives from the coordinated efforts of the homemaker supervisor, the homemaker, the caseworker, and other professional personnel, e.g., the physician, nurse, physical or occupational therapist—who may be involved in the client's total plan of care.

Homemakers are employed to perform or to assist family members in performing tasks related to maintaining or improving homemaking and

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**Statement from "State Letter #910" issued July 8, 1966 by Director, Bureau of Family Services, Welfare Administration, U.S. Department of Health, Education, and Welfare.*

child care practices; to shop, plan, and prepare meals; to supervise or care for children and for ill, disabled or aged adults; and to assist social work or other staff in assuring adequate nutrition, safety, and wholesome social environment in the home of a family or individual.

Standards for Homemaker Service Related to Personal Care

When personal care of an ill or disabled person is to be provided by a homemaker (e.g., bathing, dressing, assisting with exercises or medications, and helping persons to follow other medical recommendations, etc.), proper safeguards for both the individual and the homemaker must be provided by the agency. These include examinations and supervision of the plan of care by the physician, nurse, or other therapist, as indicated; the amount and nature of personal care for each person must be individually determined by the physician and/or nurse. The public welfare agency is responsible for assuring that its homemakers follow the prescribed personal care plan, using the help of the public health or other nurse or therapist appropriately. Specific training for the particular personal care service for each patient must be provided by the appropriate professional person (i.e., nurse, physical therapist, etc.), in addition to the general training related to the care of ill persons provided by the agency.

Principles of Administration of Homemaker Service in Public Welfare

I. *State Agency*
  A. As a first step in planning for administering homemaker service, the State plan must include the provisions set forth in Handbook IV-4244.5 and 4244.51.
  B. The State's responsibility for program development includes:
    1. Defining the specific purpose of the service and designating the individuals or groups served;
    2. Safeguarding the client's right of decision in respect to the use of the service;
    3. Distinguishing the functions of homemakers and coordinating them with functions of caseworkers and related staff;
    4. Recognizing and assuming as a statewide responsibility the need for homemaker service to extend the service, where needed, through the agency or other community resources;
    5. Providing for supervisory review and re-evaluation of the need and suitability of the service when provided;
    6. Delineating clearly the role of the State agency, assuring responsibility for: (a) distinguishing homemaker service from domestic service, (b) providing direction or supervision of the service by professionally trained social work staff, or by other staff with appropriately related training or experience, and (c)

providing for selective methods of employment, for the application of health standards, and for training for homemakers.

C. States undertaking to provide homemaker service should take into consideration the need for adequate staff to give attention to this area of program planning. While not required, in order to extend the service Statewide, a State Specialist on Homemaker Service is needed to give leadership to development of the service throughout the State. Such a staff member carries responsibility for policy development; for determining the scope and content of service; for developing criteria to assess "readiness" of local agencies to initiate homemaker service; for cooperating with field staff, staff development and other program planning staff in coordinating homemaker service with all other agency services; and for providing consultation, guide material and other program aids to local agency staff.

II. *Local Agency*

A. *Administrative Planning*

Within the overall framework of State policy, local agencies should develop specific guides and procedures governing the operation of their homemaker service program. Responsibility for directing or supervising the service should be delegated to professionally trained staff or to other staff with training and experience in homemaker service. When staff with these qualifications is not available, casework supervisors or experienced caseworkers with potential for supervision may be substituted. In these instances, the agency must plan for orientation of such staff to homemaker service through consultation by leaders in the field, institutes or workshops or brief assignments with existing homemaker service agencies.

It is advisable that staff plan for providing homemaker service for all public welfare clients who need it. The following are some of the areas which should be included in planning:

1. Defining the type of family or individual situation in which homemaker service will be provided, i.e., a situation in which a mother is ill and unable to care for her family or an aged person cannot manage certain essential household tasks;
2. Determining group for whom service will be provided, e.g., current, former, or potential recipients of agency services;
3. Providing for intra-agency referrals and records;
4. Coordinating homemaker service with the activities of social work staff and other professional persons, i.e., assuring that caseworkers and other appropriate professional persons are involved throughout the period when homemaker service is provided for a family or individual; training of caseworkers in the appropriate use of the service is essential;

5. Assuring that agency procedures and the continuing activities of homemakers protect rights of the client to privacy, confidentiality and making his own decisions;
6. Recruitment, selection, employment, training and supervision of homemakers; delineation of services to be provided by homemakers;
7. Public interpretation of homemaker service.

B. *Personnel Practices*

Homemakers must be employed as agency staff members under Merit System regulations, whether part or full-time. (Handbook IV 4244.51, item c) Salaries should be more than usually paid household workers. It is recommended that the rate be at least comparable to that paid other sub-professional personnel, such as nurse's aides or practical nurses. Health standards applied in the selection of homemakers must assure their physical and emotional fitness for the job.

C. *Training*

Adequate training of homemakers is extremely important in preparing them to perform the range of activities required in meeting the needs of agency clients. It is the agency's responsibility to determine content of training, using community resources, such as physicians, nurses, physical therapists, nutritionists and other subject matter specialists and community training facilities, to assist in the training. As important as training is, however, it should not be undertaken until an agency has done the administrative planning necessary to provide quality service.

D. *Role of Caseworker*

The caseworker is responsible for identifying the need for homemaker service as for all other agency services; for planning for the service and for facilitating the homemaker's activities throughout her assignment; and making appropriate use of agency and community specialists. Agency training for casework staff should take into account their need to understand the continuing responsibility they carry in the provision of homemaker service.

E. *Role of Homemaker Supervisor*

Homemaker supervisors are responsible for a range of activities in relation to the service. They include recruitment, selection, training, assignment and supervision of homemakers; coordinating the homemaker's work with other agency staff and professional persons in the community; agency and public interpretation of the service.

Ordinarily close supervision of homemakers within a client's home is unnecessary except in difficult assignments or those involving extensive personal care activities. In the latter instance, the nurse or therapist teaches and supervises the homemaker in activities appropriate to her level of competence. For the usual assignment, it is assumed the pre-service training and on-going staff development result in the development of a homemaker who, with experience, becomes increasingly skilled in performing homemaking tasks. Supervision, therefore, is provided primarily to help the homemaker give appropriate service; to increase her sensitivity to the less tangible emotional needs of clients so that she is better able to function as a member of the team to give moral support within her role as mother substitute for children, companion for the elderly, ill or handicapped adults, teacher for parents and older children. The supervisor's continuing knowledge of a homemaker's performance enables her to make thoughtful assignments, which take into account particular aptitudes and skills of each homemaker as well as the needs of the individual and family, and to assure agency accountability for the service.

F. *Role of the Homemaker*

The homemaker is an agency "employee," performing tasks in the homes of clients and carrying responsibilities assigned to her by the agency, working as a member of the "team" which may consist of homemaker, caseworker and various combinations of other professional persons, such as nurse, physician, nutritionist, physical therapist. She carries specific responsibilities and does not substitute for the caseworker or other team members providing service or care for families and individuals.

Guidelines Regarding Personal Care in Homemaker Services*

The conference adopted the following tentative definition of personal care, recognizing that this may be modified as more experience is accumulated by homemaker agencies and that for the present it is wise not to define it too rigidly.

"Personal care services given in the home for an ill or disabled person are those services required to help provide and maintain normal bodily and emotional comforts and to assist the patient toward independent living in a

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**Developed by Conference on Personal Care in Homemaker Services, convened by National Health Council at Arden House, Harriman, N. Y., February 1960.*

safe environment. These services, when given by a homemaker under the direction and supervision of medical professional personnel, can contribute to the realistic maximal functioning of the patient.

"The plan for service should include periodic evaluation of the patient's condition, following which specific activities may be delegated to the homemaker by the appropriate professional personnel.

"This requires direct communication between the homemaker and her supervisor and between the homemaker and other members of the team responsible for helping the patient and the family."

From this tentative definition it becomes clear that the sense of the conference was that homemakers may be taught to give the services that a family member would ordinarily perform. Although not all homemaker assignments require the giving of personal care services, many do; and as more agencies extend homemaker services to the aged and the chronically ill, the proportion will grow.

Guidelines Are Developed

The conference was divided into four workshops, each of which was assigned a special aspect of personal care: Personal Hygiene and Nutrition, Activities of Daily Living, Medications and Therapeutic Procedures, and Psychological and Emotional Aspects of Illness. Within the framework of its particular subject, however, each group was asked to focus its discussion on patients' needs; skills required; training, supervision, assignment, and recruitment; evaluation of homemakers' capabilities; and continuity of planning. Because of the unanimity of opinion that prevailed among the four groups, the guidelines that each group recommended have been merged.

Just as the 1959 National Conference on Homemaker Services recommended that homemaker service should be considered an integral part of medical care, so this conference recommended that *personal care should be considered an integral part of homemaker service.*

1. *Patient's Needs*

When a homemaker is assigned to a household where there is an ill or disabled person, she is one of a team which may include, for example, a physician, a nurse, a physical or speech therapist, a social worker, and a nutritionist, depending on the patient's needs. *The homemaker works under the supervision of the professional people, her role being a supporting or sustaining one.*

Under such circumstances the homemaker will usually have two major functions: (a) keeping house, and (b) personal services for the patient. Although the housekeeping duties may vary from one family to another, they generally will be the basic homemaker functions common to all. *The personal care duties also will vary, depending on the nature of the illness and its severity and on the availability of other family members to render personal* *care to the sick member.* In some households at some times, the homemaker may spend practically all her time taking care of the home and family and very little in giving personal care to the ill or disabled person. In other circumstances, the homemaker may be called on to give considerable personal care. All physical illness and disability are accompanied in varying degrees by psychological and emotional problems in both patient and family—for example, dependency, anxiety, regression, denial, and depression. A properly trained and supervised homemaker can meet many personal care needs for convalescent, aged, acutely or chronically ill or disabled persons. She can give the supportive or sustaining care that will help individuals help themselves in the "activities of daily living" and that also will help well members of the family help the disabled patient.

The following are a few of the specific personal care services that the conference participants discussed:

- Help patient with bath, care of mouth, skin, and hair
- Help patient to bathroom or in using bed pan
- Help patient in and out of bed, and to learn to walk with crutches
- Help patient with prescribed exercises
- Help patient regain his speech or relearn household skills
- Help patient with eating; prepare special diet for patient
- Apply heating pad or hot water bottle
- Give prescribed medicines
- Give hypodermics, under some circumstances, if there is no alternative.

If homemaker service is provided when a patient needs a variety of medical and personal care services, *the homemaker agency has the responsibility for seeking an inter-disciplinary, individualized analysis of the needs, family resources, and wishes.* Consideration must be given to the needs and resources for care of the patient on a 24-hour, 7-day a week basis. The agency must assure itself that provision is made to meet the family's and patient's needs for other services and for the times when the homemaker cannot be in the home. Periodic re-evaluation of the total situation should also be made.

The physician must recognize and assume his overall responsibility for diagnosis and for prescribing treatment. *The evaluation of patient needs and the initiation of the plan for continuity of care should be made with the physician, nurse (preferably a public health nurse), and other members of the medical care team.* The physician and nurse should decide for each patient whether the homemaker may safely give the prescribed medications.

2. *Skills Required*

Obviously the personal care skills required of a homemaker will differ from patient to patient. *After the physician has prescribed treatment, the professional personnel involved in the treatment plan should determine just which procedures the homemaker can safely carry out.* After the requirements have been determined for an individual case, the homemaker who has the needed skills can be assigned, or on-the-job training may be needed to give her the necessary skills.

In general, the homemaker may be taught those procedures that family members would ordinarily perform. Procedures involving considerable skill or judgment (such as giving injections) should not be routinely undertaken by homemakers. In some instances, however, where continuous nursing care is not available, the physician and nurse may decide that a particular homemaker already knows or can be taught the special procedure. For example, a homemaker who, after instruction by a professional nurse, has for years given insulin to herself and to a relative might well be authorized to do so on her assignment as a homemaker. *Decisions should be made case by case and would not mean that every homemaker would necessarily do the same thing even for patients with similar conditions.*

In all the discussion groups, the point was emphasized that whatever her skills, *the homemaker should not be permitted to decide by herself what personal care services she will give.* This decision will have to be made by the medical and nursing personnel in charge.

3. *Training, Supervision, Assignment, and Recruitment*

The homemaker agency should see to it that the original orientation of all homemakers includes some instruction in personal care services in addition to the usual household management and normal nutrition aspects. Physicians, nurses, nutritionists, physical therapists, and other health personnel should be used to teach basic personal hygiene and activities-of-daily-living procedures. *A simple orientation course would provide the basic preparation.* Such resources as university extension divisions, adult education centers, the American National Red Cross, and various health agencies are being successfully used by some agencies and probably should be by others. The homemaker agency should also organize and develop in-service training programs.

Beyond the basic orientation and in-service training designed for all homemakers, *specific instructions for more technical procedures should be given for particular cases as on-the-job teaching.* For instance, specific therapeutic diets should be handled on an individual basis as needed. In her orientation, training, and supervision, the homemaker needs help in understanding family food habits and the cultural and social implications of food as well as the principles of good nutrition. Enough understanding of the emotional aspects of illness can be given to help the homemaker tolerate and cope with such problems as regression and depression and observe changes in the emotional status of the patient and family.

Supervision is one of the most important aspects of a homemaker program that provides personal care services. *Continuing nursing and medical supervision is needed if the homemaker gives medications or carries out therapeutic procedures.* The agency employing the homemaker is responsible for administrative supervision, but the nurse is responsible for professional nursing supervision. This dual supervision makes close coordination extremely important. *Lines of communication should be established early so that the homemaker may maintain her identity with the employing agency and with the professional personnel as well.*

Usually the homemaker's communicative channel will be with the employing agency but provision must be made and clearly understood for emergencies. The homemaker must know under what circumstances she should call the nurse, physician, or hospital, for example.

The assignment, to a specific patient, of a homemaker who will give personal care consists of matching a homemaker's skill, personality, and abilities to the patient's needs. The agency should recognize that some individuals will be much more successful than others in the personal care aspects of the homemaker job. Usually the more experienced homemakers will be selected for this kind of assignment.

The administrative agency should periodically review its long-time homemaker assignments. Sometimes if homemaker service has been provided for a family for many months the emotional or physical status of the patient may have changed sufficiently to make a change in homemaker desirable. Or sometimes the homemaker may be identifying herself so closely with the family that her effectiveness is diluted and a change in homemaker would be advisable.

4. *Evaluation of Homemaker's Capabilities*

One of the important elements of good supervision is, of course, the evaluation of a worker's capabilities and performance. In fact, as the Arden House conference pointed out, supervision and evaluation are inseparable. *The evaluation begins when a homemaker is hired and it becomes the basis for her selection and assignment to a particular person or family.* Evaluation, of course, continues throughout the homemaker's employment.

When a homemaker gives medication or carries out a therapeutic procedure, the nurse should evaluate the homemaker's performance and should inform the employing agency of her appraisal.

The homemaker should participate in her own evaluation by means of reports to her supervisor who should keep a work experience record on each homemaker to assist in assignment.

5. *Continuity of Planning*

One technique that may be needed to assure continuity of care to a family being given homemaker service is the case conference. Reports from the physician and personal participation by all the other professional personnel providing care are used in these evaluations. Because an ill or convalescent person's needs change, sometimes from day to day, continuity of care is a major concern of the supervisory agency. Changes in the type and amount of services to be provided by the homemaker will be made as a result of decisions made at these conferences. Planning is also necessary in anticipating the termination of homemaker service—in fact, termination should be kept in mind from the beginning.

An agency providing homemaker services should periodically review its whole program to see if the community's needs are being met both qualitatively and quantitatively. Workshops to discuss methods of evaluation or community surveys may be necessary to accomplish this critical review.

Because personal care by homemakers is a comparatively new approach to patient care and one that involves new relationships with the health disciplines, studies and demonstrations are needed to explore ways of preparing homemakers to give personal care services.

Section IV

Administering and Financing Homemaker-Home Health Aide Service Programs

Homemaker-home health aide service had not developed a dominant pattern of organization, administration, or financing as of 1968. However, this section presents some of the principles of administration which have been enunciated and some of the more common patterns of development which have emerged. In addition, it discusses some of the areas which are of acute concern in this period of rapid expansion.

The first statement represents broadly accepted premises regarding the organizational requirements which will provide a sound structure for the service program. The introductory material of this Standards Code refers to the varying organization patterns, such as development within a host agency or an autonomous agency offering various types of service. Since there is considerable interest in the process of development of community support for community-based centralized homemaker programs, the second paper describes in some detail the Cleveland (Ohio) experience in establishing such a service. While the details of the approach used in Cleveland regarding the involvement and procedures of the community planning structure were developed only for that community, the nature of the process, including fact-finding re potential need and broad participation of concerned parties, is transferable to any community.

An important development for the future of homemaker service came in 1965 with the inclusion of home health aide service under Medicare (Public Law 89-97, Title XVIII). This inclusion led to a substantial expansion of home health aide services. However, there is both short and long-range pertinence to the discussion here of the major problem areas identified with this burgeoning development.

In another paper, the basic principles of administration in providing homemaker-home health aide services are defined by a pioneer in the field.

While no simple answer to the financing problems inherent in developing a new or expanding homemaker service program has been found, recent years have been marked by increasing availability of governmental funds for this purpose. Discussion of Federal support of the service in public welfare settings and an analysis of financing patterns conclude this section.

Note: For sources of funding of homemaker programs in 1966, see Appendix B, Tables 8 and 9.

The Organization and Administration of a Homemaker-Home Health Aide Service*

Homemaker service should be available to all persons who can benefit from it. How it is secured will depend largely on the size of the community, the auspices of available programs and, often, whether these programs are financed to help certain categorical groups; e.g., clients of public or voluntary social agencies, patients of a hospital or clinic, the blind, the aging or physically or mentally disadvantaged individuals and their families. Complicated metropolitan areas may best be served by a number of homemaker agencies which, without duplication, are prepared to meet special needs. There is, however, an emerging trend in several large and many small communities toward the autonomous agency prepared to offer service on a community-wide basis to a variety of groups.

Originally established as a division of multi-function family agencies—sometimes called "host" agencies—homemaker services, as indicated, are now developing under various auspices. Whatever the auspices, there must be a governing body responsible for the organization and administration of the homemaker program. This should be a board of directors in a voluntary, autonomous or "host" agency; it may be a board of county commissioners or supervisors or a board of welfare or health in an official program. Throughout the Code it is referred to as the governing body.

It is common procedure—where the homemaker program is either in an official or voluntary "host" agency—for the governing body to appoint an advisory committee or council to concern itself directly with the development of the homemaker service. Members of such groups should be broadly representative of the concerned and informed community. Although they have no legal status, these groups make a vital contribution to the agency through their understanding of administrative and service problems and their recommendations to the governing body. They also serve as effective interpreters of the agency's achievements and need for community support.

I—The homemaker agency should follow certain organizational rules.

A. A homemaker service should be established through planning by a group, broadly representative of the community, which has assessed existing community needs and resources and is prepared to focus its attention on the effective development of a homemaker program.

B. A homemaker service should be set up in an organized non-profit public or voluntary structure. It may be part of an agency with broader functions or an independent community agency under a separate responsible governing body.

Reprinted from STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, published by National Council for Homemaker Services, 1965.

C. The governing body of a voluntary agency is responsible for establishing the legal status of the agency.
    1. A constitution and by-laws should be drawn up, a Certificate of Incorporation obtained and filed with the appropriate Secretary of State.
    2. The tax exempt status of the agency should be established with the Internal Revenue Service.

D. The governing body—where the homemaker program is in a "host" agency—should appoint a group of individuals broadly representative of the community to focus its attention specifically on the homemaker service. This may be known as an advisory committee or council.

E. The governing body should be responsible for the selection and appointment of the executive of the agency, and should establish with him criteria for the selection of professional personnel, homemakers and other staff.

F. The governing body, with the executive of the agency, should determine the scope of the agency's policies and program.

G. The governing body should be continuously aware of all phases of agency operation and should be included as an active partner with the staff in carrying out the objectives of the service. It should be involved in studying problems which the homemaker service faces and in developing solutions for them.

II—The governing body should enrich the total program of the agency through the knowledge and skills of professional and lay individuals willing to serve on subsidiary committees.

A. The appropriate number of committees will depend on the size of the agency. It may be desirable, in a large agency, to have standing committees assigned to certain areas of agency operation; e.g., financing, development of program, staff education and inter-agency and broad community relationships.

B. The subsidiary committees should include representatives from broad sections of the community and not be limited to members of the governing body.

C. All committee activities should be focused on the specific needs of the agency and the problems of the individual community related to homemaker services.

D. The participation of community leaders on subsidiary committees should be one of the important avenues to community interest and understanding of the agency's program.

III—There is no royal road to financing. All by-paths leading to funds from any source, and in any amount, must be explored. It is true, at this time, that more funds, both from voluntary and tax sources, are available for homemaker service than at any previous period. It is important, therefore, that the governing body and its finance committee include members who know the giving pattern of the community, have conviction on the worth-whileness of the service and of fund raising for it, and the imagination and ability to locate and secure funds.

A. Every homemaker service which meets broad community need will require community subsidy.

B. An annual budget which covers the optimum operational needs of the agency should be prepared by the staff and approved by the governing body.

C. The governing body should undertake to insure sound financial support for the homemaker program on a continuing basis. Where the service has been initiated as a demonstration or through limited grants or contributions, there should be plans from the beginning for its on-going support.

D. The homemaker program should provide service, within the scope of its program, to people at all income levels. This service should be provided through fees-for-service from recipients, third party payments and subsidized assistance to users of the service who are not able to pay for it and for whom no third party payment is available. Arrangements for purchase of service by third parties should be in writing and should be periodically reviewed and adjusted. Whatever the payment plan for service, all users and referral sources should be informed of its true cost.

E. The governing body should explore all possibilities of financial support for the homemaker service and determine which sources are most likely to be available for the type and size of program the community determines will best meet its current needs. It should be aware of the broad possibilities for funding available through demonstration grants from voluntary and official sources, shared support through matching grants on a Federal/state basis, single or continuing grants from appropriate foundations, contributions from local affiliates of national voluntary health agencies, allocations from united funds or community chests and last, but not least, fees-for-service from consumers and independent fund raising by the agency itself.

F. The governing body of all homemaker programs—state or county commissions, boards of welfare or health, or boards of voluntary agencies—should familiarize themselves with all possibilities for providing homemaker service through tax funds. When pending legislation will allow for improved financing and functioning of public agency homemaker programs, the voluntary homemaker agency has an obligation to support such legislation.

G. The governing body and the executive should adopt accepted methods of agency accounting, including those methods set up jointly by overall national welfare and health councils to provide a uniform system of accounting.

IV—Under whatever auspices the homemaker program is established—public welfare or health, or their voluntary counterparts—there must be an executive responsible for the administration of the service; in a "host" agency he may be called a coordinator or supervisor. This role may be included in the duties of the one staff member available in a small county welfare or health department or voluntary community agency. It may be carried as a purely administrative function in an agency with broader scope, a large professional staff and many homemakers. Whether the agency is small or large, certain rules pertain.

A. The executive should head the organizational structure of the agency and be responsible for the operation of its program.

B. The executive should be responsible for recruitment, selection and employment of professional and clerical staff and ultimately of the homemakers.

C. All professional staff, clerical staff, homemakers, consultants and auxiliary personnel should relate directly to the administrative structure of the agency.

D. The executive should delegate appropriate responsibility to other agency personnel when such delegation increases the effectiveness of the program.

E. The executive should continuously appraise the homemaker program in order to make appropriate recommendations to the governing body regarding it.

F. The executive should maintain effective liaison with the governing body, should be prepared to interpret to this body the on-going details of the program and its developmental needs, and, in reverse, relay to the agency's staff the decisions of the governing body on all appropriate matters.

G. The executive should be responsible for the fiscal management of the homemaker program at all levels of its operation.

H. The executive should interpret to the community the services available through the agency's program and its need for appropriate referrals for service and adequate community understanding and financial support.

V—Once the homemaker program is established, it should search out ways to increase its usefulness. It cannot afford to stand still when the need of people for its service is so great.

A. The governing body and the executive should establish short and long-range developmental goals for the agency in relation to community need for its service.

B. The governing body, executive and agency staff should establish standards for the carrying out of the agency's program, including quantity and type of service to be offered and methods of its financing.

C. Program of orientation and on-going education for the governing body, professional and clerical staffs, homemakers, consultants and volunteers should be developed.

D. There should be provision for regular systematic evaluation of all aspects of the agency's program and structure as well as performance of its staff.

VI—Much of the success of a homemaker program will depend on how dynamic and effective the relationship is between the governing body, the executive and all other members of the staff. Adequate personnel policies and practices, thoughtfully worked out and adhered to, furnish a sound basis for such a relationship.

A. The governing body and the executive should determine what personnel policies and practices will make for the satisfactory performance of the agency's staff.

B. There should be a written manual in which specific job responsibilities, along with the personnel policies and practices appropriate to each job assignment, are clearly stated.

C. Standards in personnel policies set by professional associations and other organizations, with which both the professional and other members of the staff may be affiliated, should be recognized.

D. There should be planned arrangements for initial and regular comprehensive physical examinations for all staff members.

E. There should be a well defined, limited, probationary period for all staff. The probationary period for homemakers should include on-the-job supervision.

F. There should be clearly stated written policies for all staff on salaries, vacations, sick leave, pension plans and retirement.

G. Special consideration should be given to the insurance coverage necessary for all members of the staff of a homemaker agency: liability, accident, automobile, workmen's compensation and unemployment insurance. Regulations on type and amount of such insurance will vary from state to state. Amounts of staff salary to be withheld for insurance, including Social Security and taxation, should be established with local offices of the State Insurance Commission, Social Security and Internal Revenue Service.

H. The plan for employment of homemakers as full or part-time staff members of the agency should include fair employment practices, payment for service, at least at minimum wage rates, and coverage by special insurance necessary to job assignment.

I. Personnel policies for all professional staff—whether the homemaker program is a division of a complex welfare or health agency or an autonomous agency—should be equivalent to those employment policies established at the highest level by any comparable welfare or health agency.

VII—The effectiveness of the agency's service program should be tested through regular systematic evaluation of all aspects of its activities. All available information related to its operation should be included in such a procedure.

A. The evaluation of the agency program should include consideration of the following questions:
  1. How well does the program fit into the health and welfare structure of the community?
  2. Are its objectives meeting community need?
  3. How effective are communications within the agency, with other agencies and with the community?
  4. What are the real or potential roadblocks which may be deterrents to the agency's effective performance?

B. An evaluation of the agency's program should be carried out by its staff at least annually.

C. It is essential for the agency's growth and development that a periodic evaluation by an unbiased outside appropriate professional group be carried out.

Potentials of a Centralized Community Homemaker Service*

(The Cleveland Experience)

by S. A. Mandalfino
Executive Director
Cleveland (Ohio) Homemaker Service Association

Within a comparatively short span of seven months the Cleveland Homemaker Association, a centralized voluntary community agency, was incorporated, organized and developed its service to a level approximately 90 per cent of the budgeted minimum of 50 homemakers for 1967. The rapid rate of development can be attributed, in an appreciable degree, to almost optimum community support for the creation of a centralized voluntary service.

**Paper presented at National Conference on Social Welfare in Dallas, Tex., May 1967.*

The genesis of the new agency reflected an overall community concern for the need for homemaker service. As the nature and magnitude of the needs became more acute, it was not surprising that the problem merited and received attention and careful consideration by appropriate community groups which eventually led to an organized effort to resolve the problem.

Cleveland, like many urban communities, had provided homemaker services for many years, but only as adjunctive services primarily within the programs of family agencies, both public and voluntary. As the value and effectiveness of the service became known throughout the community, greater demands were made upon these limited services. In addition, other adjunctive programs were being contemplated. The growing demands on professional staff for implementing various agencies' basic programs, budgetary limitations and limited knowledge about requirements for an effective program, hindered progress toward the development of homemaker service to a level commensurate with community needs.

Group Reports Need for Service

In June 1960, the Joint Committee on Casework Service to Older Persons reported to the Cleveland Welfare Federation its keen and singular concern for homemaker service by pointing out that:

1. Homemaker services are part of the important community resources needed by older persons to help them maintain an independent or semi-independent existence in their own homes.

2. The provision of homemaker service may be no more costly, and frequently is less costly, than placement in a good nursing home, assuming that the homemaker service can appropriately meet the needs involved in the particular case.

3. Since it is likely that community organized and supplemented homemaker services will need to be expanded to some degree, the community will ultimately have to determine what types of service should be included and under what auspices.

4. Present information is inadequate. In order to plan more effectively in this area, formal study to clarify the quantitative and qualitative aspects of the need will be essential.

The report emphasized that "many of the questions raised by the committee with respect to homemaker service programs for older persons were equally appropriate to chronically and acutely ill adults and to programs serving children in motherless homes." The report recommended:

1. That further study include laymen and participants from the family and child care fields so that a total rather than a partialized approach might be made,

2. That such committee seek to clarify the quantitative and qualitative

aspects as they exist in relation to all categories of need for homemaker service,

3. That the committee make recommendations regarding auspices for administration of homemaker services if it is considered feasible to plan for substantially increased homemaker services.

The Welfare Federation's Planning Committee and Board of Trustees, convinced of universality and urgency of need, appointed the Inter-Council Committee of the Board of Trustees. Representation on the committee was deliberately broad and as all-inclusive as was practicable.

Named to the committee were leaders from almost every facet of community life—lay and professional, public and voluntary, business, industry and labor, and all divisions of health and welfare services. In the latter group were professional representatives of health agencies, hospitals, older person services, family and children's agencies, public housing estates, public welfare services, mental health programs, volunteer services, day nurseries, research and social planning.

Committee Requests Comprehensive Study

Resolute in its determination, the committee requested that the Welfare Federation's Research Department undertake a comprehensive study. Early in 1962 the study got under way, examining the nature and extent of need for homemaker service as expressed by the agencies providing such service, as well as needs identified by other health and welfare services. The study was confined to investigation of the expressed rather than the absolute or total need, since the latter would require a house-to-house or survey type study based on probability sampling in the community.

An assumption was made that the extent of need, especially for those whose family resources did not permit the working out of private arrangements, would at some point become known through contact with one or another of the community health and welfare services. It was recognized that if the availability of homemaker services had been more widely promoted, the number of need situations identified might have been substantially increased.

Thirty-five health and welfare agencies were invited to participate with the expectation that they might encounter need situations during the study period.

Three major areas were studied:

1. Prevalence and incidence of appropriate need situations
2. Characteristics of incidence of need in terms of:
    a. household composition and size
    b. ability to pay all or part of service fee
    c. type of problem presented and persons in the household who are the bearers of the problem

   - d. type of homemaker service required to meet the need
   - e. type of nursing service received or required
   - f. probable duration of need and amount of service weekly
   - g. geographic distribution of instances of need

3. Estimate of number of homemakers required.

In February 1964, the results of the study were presented to the community and the findings were most significant.

During the three-month study period from March 1 through May 31, 1962, 840 cases were identified by the 26 agencies as receiving or as being in need of homemaker service. Of the 609 cases already active with the identifying agencies, 373 (61.2%) were receiving homemaker service. Of the 231 new cases identified, 52 (22.5%) were accepted for service and 179 (77.5%) were not. Of particular significance was the fact that of the six agencies accounting for eight out of 10 new instances of need, three provided homemaker service, two purchased such service, and one normally was responsible for a large number of referrals to agencies providing homemaker service.

Of the 840 cases identified as receiving or needing homemaker service, about 43% were families with children and about 57% were households with aged or adult persons only. Of the 231 newly identified cases, 58% were households with children and 42% were households with aged or adult persons only.

Among the newly identified instances of need, about 42% were judged able to make full or partial payment for the service when available. The proportion able to make full payment was greater for the aged than for families with children.

Study Identifies Most Common Problems

The problems most frequently presented in the new cases, causing need for homemaker service were: physical incapacity, 55%; hospitalization (usually of the mother), 26%; and disabilities of advanced age, 12%.

Of the cases already active with agencies, 80% were judged to require service for one year or more; for the aged and adult households among these, 94% required long-term service. Among the new cases, 50% of the families with children and 84% of the aged households required long-term situations. Needing service for four months or less were 37% of families with children and 10% of the aged households.

Service time required varied widely from a few hours per week to seven days' service for 24 hours a day, the aged households needing proportionately more service of fewer than 16 hours per week (41%) than families with children (16%).

The number of full-time additional homemakers required to meet fully the expressed need in cases already known to agencies and in those arising in the course of one year was estimated to be 459—247 for households with children and 212 for service to the aged. At the time of the study, the County Welfare Department employed 71 full-time homemakers, the Family Service Association 21, and the Jewish Family Service 10, a total of 102 homemakers for the entire community. The estimated need was over four times that which was available.

Of the 840 cases identified, roughly 37% were cases known to or identified by public assistance programs. Among cases known or identified by other agencies a significant number could qualify for public assistance or were marginal cases. Of significance is the fact that a substantially higher proportion of unmet need, relative to total need expressed, existed in the area beyond the City of Cleveland.

Inasmuch as the Public Welfare Department was the principal supplier of homemaker service, the study questioned whether homemaker service to suburban residents was as readily available as it was to Cleveland residents, similarly to non-public assistance families as to public assistance families.

Publicity given to plans for the creation of the new agency brought a response of such magnitude from individuals and families not known to any health or welfare agencies that the Community Information Service assessed the volume of need from this group as about equal to that identified by the study.

The findings of the study served to place the need for homemaker service high on the list of priorities for community action and support. The Family Service Association, knowing of the establishment of a centralized community homemaker service and faced with having to use its resources of staff and budget for its basic service, discontinued its homemaker service program as of December 31, 1965. Temporary programs were started. The Visiting Nurse Association took on seven of the Famliy Service homemakers as part of a new home care demonstration project. Anticipating the creation of the centralized homemaker service, the Jewish Family Service Association expanded its basic program of 12 homemakers by developing a temporary project of six homemakers. It was expected that "eventually" the temporary project would be taken over by the centralized service.

Since the County Welfare Department had by far the largest homemaker service, the Inter-Council Committee urged that first steps to provide additional homemaker service be taken by the county. It was further proposed that, should expansion of the county program prove successful, homemaker service to voluntary agencies' clientele might be arranged through cooperative financing.

The County Welfare Department at this time was beset with problems of reorganization and, furthermore, the director and assistant director were about to retire. These and other factors prompted the public agency to determine that any expansion of its homemaker service would have to be related to the needs of public assistance cases.

The Welfare Federation and the Inter-Council Committee for Homemaker Service, determined to expand homemaker service, explored other alternative organizational approaches to realize their goal.

It was concluded that adequate development of this program required the primary and full attention of a strong management group—board and executive leadership. Since prospects were good that a homemaker service agency program could become quite large in a few years and would require its own leadership, no matter how it was structured, it was doubtful whether much, if any, saving could be achieved through establishing the service under an existing agency.

Community Agency Is Created

Finally, the combination of social welfare and health problems which homemaker service aimed to ameliorate was one which did not lend itself to administration through an existing agency. Thus, as a joint venture of interested agencies through the medium of the Welfare Federation, the Cleveland Homemaker Service Association was created as a voluntary community agency to work cooperatively with and complement the County Welfare Department homemaker services, with expectations that the public agency would expand to meet the growing need of the recipients of public assistance and public child welfare.

From more than 100 nominations for board membership made by the boards and executives of the agencies and organizations involved in the homemaker study, a board of trustees of 21 members was elected. This was truly a unique board because its members were experienced leaders from boards of trustees of other agencies interested in homemaker service and all had demonstrated ability in getting programs into action.

The trustees met for the first time on June 6, 1966 and arranged to have the agency incorporated on June 22, 1966. The charge to the trustees and to the agency was to serve the homemaker-home health aide needs of the clients and patients of voluntary health and welfare agencies; to serve the general public on an ability to pay basis; and to serve governmental agencies to the extent that this is feasible on a purchase of service basis.

Other functions of the agency would be:

1. To recruit and train people for homemaker-home health aide work (working with other community organizations which could provide various aspects of entry training and possibly finance parts of the program),
2. To refer homemaker-home health aides for assignments to cooperating agencies which would provide professional supervision on a cooperative basis with homemaker agency staff,

3. To provide professional supervision to homemakers placed in homes of families not known to any health or welfare agency.

The sponsors of the agency decided to provide for the development of an agency of "viable" size so that the service might be of sufficient volume to operate efficiently and it would not spend undue time in processing requests which it could not satisfy. With such provision, there could be great potential for growth.

Budgets Established for Three Years

The budgets for the first three years of operation were established to finance minimum levels of operation. It was considered important that the service be developed as rapidly as possible, rather than plan on a prolonged "phasing-up" of the service. Inherent in this financial plan was a recognition that the level of service should go far beyond the budgeted minimum. To allow for this, the Welfare Federation departed from a long-standing policy and assured the agency that income which exceeded the regular budget appropriations would not be deducted from the Federation's grant, as is customary, but should be used to expand service. In addition, to subsidize diminishing foundation grants and to cover some increase in service, the Federation committed allocations of $75,000 for the first year, $125,000 for the second year and $175,000 for the third year, provided the United Appeal campaigns were successful in these years and that the agency's performance was satisfactory.

For the growth period of three years, $327,000 in foundation grants was needed. The Welfare Federation obtained two grants totalling $55,000—$25,000 from a foundation interested in older persons and $30,000 from the Junior League.

The board of trustees, within a few months after being organized, succeeded in obtaining numerous grants from diversified community foundations. To date, three-fourths of the foundation grants have been realized, with assurance that the balance would be granted in the second and third years as needed. Since the centralized voluntary homemaker-home health aide service would serve a wide spectrum of community needs, including the needs of people who could pay for service, it was anticipated that $40,000 in fees could be realized in the first year, $60,000 in the second year and $80,000 in the third year.

Eventually, about two-thirds of foundation support could be replaced by fees and one-third by Welfare Federation subsidy. The support from Medicare, from sale of service to non-financially participating health and welfare agencies and from other third-party sources, is considered to be of sufficient potential to permit the growth of service to levels substantially above the level made possible within the basic, structured budget.

Homemaker service to the community was instituted on January 1, 1967 with the transfer of temporary projects from the Visiting Nurse Association to the Cleveland Homemaker Service Association. Additionally, working jointly with the Manpower Development and Training Program, field placements for 12 trainees were arranged with families known to three voluntary health and welfare agencies, with supervision provided on a cooperative basis. The placements were made with the plan that upon completion of the block of field work, if the homemaker were still interested, she would continue serving the same family as an employee of our agency.

Since January 1, all requests for homemaker-home health aide service, other than those handled by the County Welfare Department, have been directed to the new voluntary centralized agency. Up to April 19, 307 applications were received and processed. A total of 108 families were served; 299 families were not served, for a variety of reasons: for 174 families, there was no homemaker available; 88 applications were withdrawn as alternate plans were made. Inappropriate requests totalled 27.

Despite the reticence of some professionals to make referrals at this period of our development, referrals to meet crisis and emergency situations were received from a total of 31 different organizations: 12 hospitals, the Visiting Nurse Association and two other health centers, four family agencies, three boards of education, three community centers, the Office of Economic Opportunity, the Juvenile Court, the Cleveland Guidance Center, Division of Child Welfare, Aid for Aged, and the Chamber of Commerce. About twice as many referrals were received and processed from the general public (individual persons needing service, families, doctors, employers, attorneys, etc., not known to agencies) than from health and welfare agencies.

Agency Sets Priorities of Need

To meet properly the surge of requests for homemaker-home health aide service, it became necessary to set priorities of need. In all cases, criteria had to be developed against which the urgency of need was judged. Consequently, for the first time, a single set of criteria is being used in the community and service is provided no longer in accordance with varying priorities and standards of individual agencies. Evaluations of need are made either by the referring agency's professional staff or by our own social service staff. In those situations in which there are indications of a health problem, evaluations are made by the Visiting Nurse Association district nurses.

Before placement of a homemaker-home health aide is made, a preplacement conference is held with the caseworker and/or nurse, the homemaker and the agency's homemaker supervisor to discuss service to be provided. The homemaker is then accompanied to the home by the cooperating agency's social worker or nurse or, in instances where no community agency is active, by our social worker.

Continuing supervision and consultation have been arranged for all cases. In cases involving a health problem, the VNA presently assumes responsibility for nursing supervision in a joint relationship with our staff and other social agencies' caseworkers.

A variety of needs have been served. Because of urgency, approximately 70% of the cases have been situations of physical illness or incapacity; 20% of the cases have been motherless and/or multi-problem families, and 10% were those with mental illness. As the level of service grows, it is expected that more motherless families will be served. Because of the limitation of homemakers available, housekeeper service only is not being offered. This priority restriction has ruled out service to a great many aged persons to whom such service could have been most beneficial. Future expansion of service will permit the agency to serve this area of need as a preventive measure.

In seeking to provide appropriate auxiliary services for families being served, the agency has become a focal point for joint planning for total family needs, using many community services. Already, meaningful communications have been established with numerous agencies and it appears that there is wide interest in cooperative planning.

The recruitment of homemaker applicants has presented no serious problem to date. Initial publicity about the creation of the new agency provided the greatest number of prospects. Some applicants had been neighborhood staff members of poverty programs which were phasing out and also the Community Information Center of the Welfare Federation had kept a list of women who had expressed interest in our program. About 95% of the prospects came from the central city.

Subsequently, undue travel time and problems of transportation restricted service to the outlying areas of the city and the suburbs. To rectify this situation, the Junior League has undertaken a project to stimulate interest in homemaker service. Presentations will be made by League members to almost every church women's group in the outlying areas covered by the Greater Cleveland United Appeal. Their first effort will be concentrated in middle class communities. Another approach to recruitment has been to ask agency workers in outlying areas who request service to aid in recruitment, either by suggesting prospects or by putting us in touch with appropriate groups for a recruitment effort. Finally, the most effective recruiters have been members of the homemaker staff who, knowing precisely the type of person needed and the duties of the job, were able to refer friends and acquaintances.

It was decided that it was necessary to pay as adequate an hourly rate as possible at the very outset. The board of trustees readily approved the new minimum hourly rate of $1.40, with provision for an increase of five to 10 cents per hour after a probationary period of three months, with merit raises thereafter. Fringe benefits, including vacation, holidays, accumulated sick-leave, were helpful in recruitment.

Selection Process Proves Successful

Dealing with a large number of applicants, it has been possible to be most selective. No formal education qualifications were set. We looked for well-adjusted adults who possessed flexibility and warmth, willingness and capacity to learn and a good sense of humor, as well as the other usual requisites. For each person selected, five applicants were seen. This truly was a gargantuan task, but the results have more than justified the effort, for only three of the 35 new trainees either withdrew or were dropped.

Having to provide homemaker-home health aides to serve the most emergent cases, we were compelled to institute homemaker training classes sooner than was anticipated. With the generous assistance of the Visiting Nurse Association, the Family Service Association and the teaching contribution of two instructors who hold masters' degrees in social work and home economics, it was possible to design and conduct a training class for 15 trainees in February and 20 trainees in March.

The training program was geared to the educational, cultural and experience backgrounds of women who are generally quite unsophisticated but innately intelligent and mature. For expediency it was decided to hold to a two-week program of six and one-half hours each day, five days per week. A longer period of formal classroom instruction presently is considered desirable and future plans will take this into consideration.

The content of the training program covered four primary areas: social work concepts of the family and child, basic health instruction (by VNA), home economics and nutrition, and orientation to working as a member of a multi-disciplinary team. Emphasis was placed on meeting the needs of the clients and patients rather than on housekeeping responsibilities, and teaching was directed toward the role of the homemaker-home health aide in problem-centered situations.

Since the last training program there have been discussions with the Red Cross, the Nutrition Association, the Adult Division of the Cleveland Board of Education, the Cuyahoga Community College, and the Division of General Studies of Cleveland College of Western Reserve University, all of which are interested in cooperating in the structuring of a unified community training program for homemakers. The possibilities of such a program are countless and, hopefully, the agency and the community can capitalize on them.

With but a few months' experience, it is too soon to formulate any accurate assessment regarding the inter-relationships between our agency and the numerous cooperating health and welfare agencies. By now, almost every agency has knowledge of our service and most have been in touch with us. It can be said that generally there is satisfaction in having a centralized agency with which to work; this has been especially true of the hospitals and miscellaneous health agencies.

The area requiring greatest attention by the administrative and social service staff is that of working out joint responsibilities between the agency requesting service for its client or patient and our staff with regard to the supervision of the homemaker-home health aide and the need for continuation of service. Depending upon the type and quality of supervision or consultation available to the homemaker from each referring organization, an individual plan of cooperation is worked out. A program of joint evaluation has been accepted by all and has proven to be valuable for on-going assessment of the service and future planning.

It is worth noting that, since the creation of this agency, the County Welfare Department has promoted the person who represented the agency on the Inter-Council Homemaker Service Committee to the position of executive director, and reorganization of the total agency has been instituted. Because of his interest and conviction regarding homemaker services, the volume of service has doubled to a level of 140 homemakers with plans to expand to 190 homemakers by year's end (1967).

Around-the-Clock Service Developed

An outstanding development has been the creation of a 24-hour, seven-day per week, emergency homemaker service attached to the County Children's Receiving Home and available to all divisions of the County Welfare Department. This service has proven to be most effective and will be expanded.

To date, responsibility of public and voluntary services has been divided so that, in general, the county serves wards of the county and public assistance families and our agency serves all others. Of course, there have been some situations where service could be provided by either organization and these have been handled on an individual basis, with frequent clearances between the two agencies.

It has been most evident that, to function effectively as a centralized homemaker service, we need a professionally qualified staff for key positions in social work, nursing, home economics and nutrition to give leadership and to handle the multiplicity of situations presented by the host of community agencies.

Because of the nature of the total community need for homemaker service, it has been most advantageous to have the agency oriented primarily to social work. It is recognized that nursing services require professional attention and that the combined programs of social work, medicine and nursing should be appropriately correlated. To achieve this end, the board of trustees has appointed an Advisory Committee on Home Health Aide

Service. Membership includes our trustees, who not only are familiar with family and children's work but who have served on boards of health agencies; representatives of two public health nursing organizations, the Chronic Illness Center, the Visiting Nurse Association and two representatives of the medical profession who have had interest in and experience with home health aide programs. The committee will work with the agency's staff and the community to recommend standards and procedures for nursing supervision and personal care in home health aide situations.

To assist the agency and the community to plan for further development of the program, a record of all requests is being kept, forming a central register of need on a continuing basis. Such records, heretofore, have not been available and already current trends of need are identifiable.

Despite our limited experience, it appears that for the Cleveland area, with its network of health and welfare agencies, a centralized service has many advantages. The community has enjoyed the inter-disciplinary approach to social and health problems for many years, and through the capable and effective leadership of its Welfare Federation, agencies have been working cooperatively toward providing the best solution for total community needs.

To date, the outstanding achievement has been the ability of the centralized agency to provide, for the first time, homemaker service that has not been fragmented. The needs of the general public, previously almost unserved, are being served in a manner which permits the identification of problem situations which heretofore had gone undetected. In some situations where there had been resistance to casework and nursing service, the homemaker has bridged the gap.

These first months of our existence as an agency have been exciting and rewarding ones. From our experiences, we have been encouraged in our belief that a centralized community homemaker-home health aide service has greater potential for growth and for meeting total community needs than a fragmented approach by numerous individual agencies. Although there are varying philosophies and concepts which must be mutually resolved as we further develop our service, we cannot conceive of a more effective means of achieving a satisfactory resolution of differences than through a centralized service with proper community support and with a competent staff providing the expertise of many interested professional disciplines.

Special Implications of Public Law 89-97, Title XVIII*

by John W. Cashman, M.D.
Director
Division of Medical Care Administration
Bureau of Health Services, Public Health Service
U.S. Department of Health, Education, and Welfare

Let us consider the problems which confront us in improving home health services programs. In my Division, we have identified at least eight problem areas which can be more specifically attacked at the community level than is possible at the national level. I would like to list them briefly and suggest particular ways in which board members, agency executives, and supervisors can help make Title XVIII extend its usefulness. These eight areas are:

1. Lack of understanding of home health services among consumers, providers, and fiscal intermediaries;
2. Financial problems of agencies that can be attributed to (a) faulty initial planning, (b) precipitate withdrawal of community funds, (c) the necessity to design and maintain a complex set of financial records, (d) unfamiliarity with deductibles and co-insurance, (e) no previous experience with fiscal intermediaries, (f) contracting by home health agencies for home health aide service;
3. Failure of agency staff to understand the significance of some of the Conditions of Participation and the interrelationships among them;
4. Lack of experience and know-how concerning the organization and effective use of medical advisory committees;
5. A long-standing pattern of insufficient attention to the form and substance of patient records, particularly the clinical records;
6. Shortages in most of the kinds of personnel needed to staff a home health agency;
7. Outmoded personnel policies, including state and local civil service requirements that call for full-time staff;
8. Difficulties in achieving harmony among the several home health agencies a community supports.

To increase public understanding, the Public Health Service and the Social Security Administration both carry on extensive information programs for beneficiaries and providers. But this is not enough. Board members can

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**From paper given at Annual Meeting, National Council for Homemaker Services, New York City, May 4, 1967.*

be extremely successful in state and local communities because so many of them are involved on several boards and have extensive community relationships. Agency executives can make an enormous contribution by arranging for physicians, and the staffs of areawide planning agencies and fiscal intermediaries, to visit the home health agency and also to take a few key people on one or two visits to patients. We have tried this expedient with Federal staff whom we were indoctrinating and know that it works. Home health agencies in the District of Columbia and nearby Maryland and Virginia were most generous in showing the staff how the service operates. Many of these people had seen movies of home care programs, but they could not visualize the central office with its busy switchboard and empty desks, on the one hand—and on the other, the busy nurses, aides and social workers who adapt to so many variations in the patient's home. Some have everything with which to care for sick people; others have very little. The satisfaction of the patient and his family has to be seen and heard to realize what this service means.

Financial Problems Noted

To rectify some of the financial problems, some state and local communities have established regular meetings between providers and fiscal intermediaries to identify ways in which forms in use can be evaluated and improved. These meetings may be regular or intermittent.

Community chests and councils and other sources of support will need reminders that home health agencies will not be self-supporting. In fact, unless the distribution of patients receiving care under Medicare, Parts A and B, changes materially, the financial condition of the agencies is likely to worsen. Especially in states which place much emphasis on township and county lines, there is need to help the small agencies consider merging with a nearby agency to assure a more effective and stable program. This takes a bit of doing, but some of the smaller agencies are in effect "paper" programs which would be vitalized by consolidation with a nearby program.

Board members can be helpful to agencies long used to operating such programs and reluctant to give up their autonomy by joining forces with a nearby community.

And finally, a word about the financial problems of many of our young member agencies which have contracted with a home health agency to provide home health aide service. The payment process is not yet working smoothly in all parts of the country. When payments from Medicare are not truly on a current basis, this means delays in payments to the homemaker-home health aide agency.

Conditions Not Understood

The 24 Medicare Conditions of Participation are purposely grouped in three sections or chapters. The first eight conditions deal with the agency, its functions, structure, and general overall policies. The second chapter deals with each of the services individually. And the third chapter deals with the acceptance of patients, the plan of treatment, orders for drugs, and clinical records. This organization was designed to help influence changes in old agencies and to provide a sound beginning for new ones.

When these relationships are understood, for example, we shall know that the 24 Conditions require that all certified agencies are so designed as to meet the definition of the former "coordinated home care" program, and we can substitute the phrase "home health agency" to embrace agencies under several different auspices. Similarly, we welcome the hyphenated phrase "homemaker-home health aide," in order to take full advantage of the implications of the four Conditions on home health aides. This hyphenated phrase is already widely used and should facilitate understanding between health and social welfare agencies.

Advisory Committees Required

This organization knows well the strengths of boards of directors and professional advisory committees. One of the Conditions of Participation for home health agencies deals with a professional advisory committee which the law requires. These committees vary greatly in size, composition and effectiveness. But they are not uniformly well used. As part of the evaluation of any agency, we suggest that there be a periodic review of the minutes of meetings held during the last year.

Were they held fairly regularly? Were they well attended? Did the sub-committees function effectively? If there are no sub-committees, do the minutes indicate that more could be accomplished by appointing sub-committees? Is the committee broadly representative of the community? Does it include representation from the various agencies and groups with which the home health agency works? In workshops and other meetings, discussions on how to organize and use an advisory committee can be valuable, especially if a bibliography and samples of well-written minutes are used as models.

Record Keeping Needs Study

Patient records, especially the plan of treatment and clinical records, deserve similar study. Many long-established agencies and some new ones have good forms. If these agencies would collect sample records which have been filled out for patients under care, they would be extremely useful. Such a proposal all too often results in a committee to design a set of new forms—but that is not the intent of this comment.

Personnel Shortages Are Serious

Personnel shortages are so widespread and the measures for their solution are so numerous that I won't take time to spell them out. You have been more successful than most health resources in developing a fairly large group of ancillary health workers. For this reason, I hope that you will share your recruiting and training experience with other agencies. Perhaps the most pressing difficulty is represented by state and local civil service requirements that staff be employed full-time. These must be altered if we are to take advantage of a substantial pool of nurses, therapists, social workers, and home health aides who can be recruited for part-time employment.

Harmony Must Be Achieved

My final recommendations concern a problem which we did not anticipate—how to achieve harmony among several home health agencies in a community. Medicare provides a tremendous stimulus for improving the health systems of this country. But it went into effect in a very short period of time. We find in a number of communities agency executives who are over-concerned with doing business as usual even though the new legislation provides incentives for long-needed improvements in various medical care systems.

In homemaker-home health aide agencies some of the problems arise because most such agencies are not also certified home health agencies. Formal contracts with a certified agency have not always proven the perfect solution. Some of the home health agencies seem not to realize that the homemaker-home health aide agency may have been in operation for many years; and that the consumer group it has long served is much larger than the aged population entitled to Medicare. Such an agency continues to receive and respond to calls for service from its clients. Some home health agencies have had difficulty in understanding and accepting the fact that the homemaker-home health aide agency is not a satellite of the home health service agency. Board members and executives alike will need to devote special attention to such situations to weld a true partnership among the agencies.

A similar situation exists in some communities where the nursing agency has long provided bedside care to large groups of chronically ill and aged persons who have received all or most of the remaining services required for comprehensive medical care from another agency. Yet, the nursing agency has not been disposed to enter into an agreement with such agencies to enable them to be certified as home health agencies. Thus, in many of our large metropolitan communities these non-certified agencies are deprived of financial support from Medicare. Moreover, these communities are not moving as rapidly and effectively as they could to round out a program which really meets all the needs of homebound patients for part-time care. I recently visited several patients more than 65 years of age who were paying for home health aide service although they would have been entitled to it, had there been an arrangement between the two home health agencies in the community and the home health aide service. Board members and executives alike can expedite the development of such arrangements in many of our large cities.

Before Medicare was implemented, it was agreed that the functions of the state agency working with the Social Security Administration should consist of three basic elements: certification, consultation, and coordination. State agencies have made great strides in implementing the first two of the "Three C's," and local agencies providing service have done their part very well in becoming certified and making use of the consultation offered. The almost superhuman task of certifying providers has been accomplished. It remains for us to make a comparable effort in advancing common understanding of the coordination function.

When we achieve harmony among the various agencies and programs which now make up the total array of resources through which the patient sick at home must find his way, we shall have reached the goal of coordination.

Basic Requirements for the Administration of Homemaker Service*

by Ellen Winston
Former U.S. Commissioner of Welfare
Department of Health, Education, and Welfare

As we strive to meet community needs, we must keep always in mind the three basic requirements for effective homemaker service:

1. *Broad scale programs which service families with children, aged, ill and disabled adults in the community.*

Increasingly, communities are looking to welfare and health agencies to provide a full range of services for all who need them, not just a selected few according to very restrictive policies which these agencies set up.

2. *Responsible administration which assures a quality service in appropriate amounts, as needed.*

**From paper given at Annual Meeting, National Council for Homemaker Services, New York City, May 4, 1967.*

This means that the agency must be responsible for the quality of the persons selected to be homemakers and provide suitable training and direction of them. They must be as much a part of the agency as caseworkers, nurses, secretaries or other staff, responsible to the agency, which in turn must be accountable for those workers, as for other staff.

Responsible administration means that the agency, through appropriate staff, must review and evaluate requests for service, determine if this or some other service is needed, and what other services must be provided along with homemaker services. It does not mean that homemakers can operate on their own, making their own decisions as to whom they will serve, how much, what they will do, etc. It also means a pay scale for homemakers and aides commensurate with the tasks they are to perform, as well as other employee benefits.

It means that other agency staff will be a part of planning and carrying out this service, and that the total plan of service—social, health, financial and other—will be coordinated to meet the specific needs of each family.

3. *Accountability to the community for quality, quantity and cost of service provided.*

Community means local, state and national and it means clients are citizens and are a part of the total community. It means informing the total community of available services and of the unmet needs. It means involving the community in developing needed resources and extending services, in casefinding and assuring that service is accessible to all who need it.

As of this point in time we cannot honestly claim that we have achieved programs which uniformly reflect all of these principles. We still have many problems to be resolved. Our goals should certainly include them.

Federal Support for Homemaker Services in Public Welfare*

by Ellen Winston
Former U.S. Commissioner of Welfare
Department of Health, Education, and Welfare

Community leaders seeking ways of making homemaker service available to all groups who need it inevitably are concerned with financial resources for the support of these programs. While over the years there have been many new developments in the area of financing, funds available from

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Federal sources offer the greatest potential for on-going support of homemaker service programs to meet a wide range of community needs. Major sources of Federal funds are those available to state welfare departments through the public assistance and child welfare service programs.

For child welfare services, the Children's Bureau administers Federal grants which are apportioned among the states on the basis of a formula specified in the law. The funds are allotted only to state public welfare agencies. They are for the purpose of aiding the state agencies in establishing, extending and strengthening public child welfare services. State plans for financial participation in the costs of child welfare services are developed jointly between the states and the Children's Bureau.

The Federal policies provide for services for children on the basis of their need for service without regard to the economic status of the family. The state agencies have wide latitude in developing their child welfare services plans. For the fiscal year 1965, 34 states made provision in their plans for homemaker service. Those which made provision for homemaker service may provide for staff for state positions of leadership to stimulate and develop programs or for employment of homemaker service staff and other related costs in providing service in local communities. They also may provide for purchase of services from voluntary agencies and develop cooperative projects with other public and voluntary agencies.

Special Funds Are Available from Children's Bureau

Funds for maternal and child health and crippled children's services administered by the Children's Bureau may be used to purchase homemaker services, provided the need for such services is directly related to other services being offered through these programs.

There are special child welfare research and demonstration funds also available through the Children's Bureau which can be used in connection with homemaker services. These funds are available to either public or voluntary agencies and institutions of higher learning. The projects must be of regional or national significance. An example of such projects is the one which demonstrated the use of homemaker service for families of mentally retarded children.

Grants-in-aid are available through the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare to states for costs involved in carrying out their public assistance and social service programs. These programs must be administered by state and local departments of public welfare in accordance with a state plan which meets certain requirements based on Federal law and policy. When Federal requirements are met and the state's plan is approved, funds for providing services, such as a homemaker service program, are made available on the basis of 75 per cent Federal and 25 per cent state and/or local funds. If homemaker service is included in the statewide plan, Federal funds can be used to help finance it even though an organized homemaker program may not be currently operating in all counties of the state. The amount of Federal funds available to a state for providing services is limited only by the amount which the state wishes to spend as its share in the costs.

Federal public assistance funds can also be used to help finance homemaker demonstration projects. Such projects can serve a single community, or even a neighborhood, since their purpose is to test new approaches or collect data that will enable the state public welfare agency to strengthen its homemaker service, as a part of its statewide plan.

Homemaker services, financed through the public assistance program either as a demonstration or as part of the statewide plan, may serve families with children, as well as aged, ill, and disabled individuals and families. These programs need not be limited to public assistance recipients but may serve other low-income groups, if the state elects to include them.

There are several important reasons for encouraging local public welfare agencies to develop and operate their own homemaker service programs. First, the number and scope of homemaker service programs needed to meet the variety of needs among people served by the public welfare agencies require financing through public funds. Second, homemaker service for people served by the public welfare agencies needs to be closely coordinated with the agency's total program of social services available to individuals and families. Third, once initiated, the Federal share can be maintained as part of the permanent program.

In addition, Federal matching funds for purchase of homemaker service from other community agencies are now available to local welfare departments as a result of the 1967 amendments to the Social Security Act.

When home health aides are used in public assistance medical programs to participate in home care of patients, funds can be used to help provide these services if they are performed under the supervision of a physician or nurse.

Section V

The Development of Homemaker-Home Health Aide Staff

This section treats those crucial areas of program operation which determine the quality of the service given; that is, the activities which identify and develop staff competence. It is frequently stated that one of the fortunate aspects of homemaker service is that there is a large supply of potential homemakers since the field does not require a high level of formal education and since many of the skills needed have been acquired to some extent by many women in their roles within their own families. However, the quality of homemaker service is dependent upon the shaping and development of this potential so that the staff can function appropriately and effectively in their unique role of homemaker-home health aides.

The twelve papers presented in this section deal with the four major elements of staff development—recruitment, training, supervision, and team relationships.

The ability of a homemaker program to recruit and select competent, well balanced individuals as potential staff members is the basic underpinning of the program's capacity to help individuals and families. The process of finding the best possible candidates for homemaker positions is discussed thoroughly here, moving from general standards to current practices in the field.

While there is general acceptance of the need for training of homemaker staff, both at the time of their employment as staff members and while they are on the job, the form and content of such training differ widely. Various patterns of training found to be successful in the field are examined in some detail here.

The supervision received by a homemaker falls into two categories. The first is a part of the continuing working relationship between the individual homemaker and the supervisor of the homemaker program or of her particular staff unit. The second category is the case-by-case supervision of detailed responsibilities in a particular service situation. The latter type of supervision is commonly received from the nurse or caseworker in charge of the on-going health care or social work plan for the family being served. The continuing supervision of the homemaker carries a responsibility that is both administrative and educational.

Usually, a homemaker functions as a member of a team, each of whose members carries defined responsibility for one aspect or another of the particular problem faced by the family or individual receiving service. Most commonly, the homemaker's role in the situation is defined by the social worker or nurse who is responsible for the overall plan for the family. The two papers that conclude this section illustrate the complexity of team relationships in both a social welfare and a nursing setting.

The Staffing of a Homemaker-Home Health Aide Service*

I. The unique contribution of the homemaker program is the direct service given by the homemakers to people in their own homes. Major efforts of the agency are directed toward making this service meet the various needs of applicants for it. Obviously the success of the program depends to a large degree on both the quality and quantity of individuals recruited as members of the homemaker staff. It is generally assumed that most communities have a reservoir of woman power—men, too, make excellent homemakers in certain situations—that can be drawn on by a homemaker agency for such personnel. Often a beginning agency, or one limited in staff, will employ few homemakers and many of them on a part-time basis. Nevertheless, since the need will probably increase for the service, the agency should establish at the beginning—and broaden as the program grows—an effective pattern of recruiting homemakers.

A. A sub-committee of the governing body, with the executive, should work continuously to establish an effective on-going program of recruitment of homemakers.

B. All appropriate means of communication should be utilized by the agency to attract homemakers to its program; e.g., case stories told on various news media; appeals to church, Red Cross, home nursing and PTA groups; requests to state employment offices; encouragement to homemakers themselves to spread the word.

C. Homemakers should be recruited either for full or part-time service in accordance with the demands on the agency and the ability of the homemaker to meet full or part-time job assignments.

D. Interpretation of personnel practices of the agency and job satisfactions should be emphasized in recruitment programs.

E. Individuals with special knowledge—different cultural backgrounds, languages, experience with various groups of children, older people, chronically ill—should be sought by agencies in order to provide a variety of understanding to meet special situations.

II. Once a potential homemaker applies to the agency, skill in deciding on her ability to perform necessary job assignments is of paramount importance. Many people who have worked only within the protection of their families, or on minor jobs, are inarticulate in the formal surroundings of an agency office. Often the more inarticulate ones, when acclimated, will make the best homemakers. The executive or staff member responsible for

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selection of the applicant as a homemaker will need to consider not only reference statements, attitudes and abilities observed initially, but, even more especially, on-the-job performance during the first work assignments.

A. A comprehensive initial interview with the applicant should be carried out by the executive of the homemaker service or a designated qualified assistant.

B. The homemaker should be chosen for a number of personal qualifications including her interest and concern for people, a warm out-going and pleasant personality, flexibility in, and objectivity toward, her work.

C. Reasons for the applicant's interest in the service should be explored in depth with emphasis on personal experiences that have influenced the individual's application and her attitudes and feelings regarding potential recipients of her help; e.g., children, the aging or the sick.

D. References should be secured from other than family members: previous employers, clergy, doctors and personal friends.

E. Careful observation of the individual's attitudes and job performance should be carried on by the supervisor of homemaker service during the training and probationary period.

III. It is generally conceded that homemakers functioning under the supervision of the professional staff of a community agency should be mature women with adequate knowledge of food preparation and housekeeping procedures; with good judgment, patience, considerable skill in human relationships and, hopefully, a sense of humor to help them meet all sorts of atypical situations in a home. It might well be added that for those involved in personal care for both children and adults, a strong back and some knowledge of body mechanics are assets. No standard has been established in the Code on a recommended age for homemakers, since it is agreed that maturity is not necessarily related to years lived.

A. The homemaker should possess both good physical and mental health and should demonstrate maturity of attitude toward her work assignment.

B. The homemaker should demonstrate ability to work under supervision as an employee of the agency.

C. The homemaker should have had, or receive following her agency appointment, adequate training and experience in home management and in the care of children, the aging and chronically ill individuals in various disease categories.

D. The homemaker should be able to deal with minor emergencies which will arise on her assignment and to work under stress when a crisis occurs. She should recognize her limitations in meeting emergencies and crises beyond her ability to handle and be able to report them appropriately to her agency control.

E. The homemaker should be able to read, write, follow written instructions and to converse easily on the telephone.

F. The homemaker should be able to communicate orally with the family to which she is assigned and both orally and in writing with the agency representative to whom she is responsible. She should be able to maintain the statistical records appropriate to her job assignment.

G. The homemaker should understand and respect the need for confidentiality in regard to the details of her assignment, and the problems of the family involved.

Recruitment and Selection of Homemakers*

"True, training and supervision are most important, but wise selection must come first. Recruitment is but a tool to accomplish this; screening and evaluating are the essential functions," asserted one of the participants in the conference.

How does the homemaker become part of the team? Conference participants agreed that the successful homemaker is more born than made. But they carefully balanced that belief with the essential conviction that carefully planned training is important.

Those who know homemaker programs best stressed over and over the fundamental requirement of certain characteristics. These are warmth, concern for people, tolerance, emotional maturity. "Inherent ability to give of one's self in helping others" was the way one speaker expressed it. But it is equally important to foster new dimensions of skillfulness, and the preparation to serve. This includes self-discipline, organization, and perceptiveness, achieved through carefully planned, sound training. "In recruiting and screening, we find only a potential homemaker. Many skills and latent abilities are developed through the training course, supervision, and on-the-job performance. At the beginning we are looking for certain basic qualities and potentials upon which to build," one person summed up.

Recruitment

How do agencies find these potential homemakers? The means employed almost run the gamut of human communication. Often, at first, agencies rely heavily on newspaper stories and advertisements to reach prospects. But

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**From REPORT OF 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES, published by National Council for Homemaker Services, 1965.*

with more experience their efforts are based more on personal contact—talks before women's clubs, church and other community groups, and contacts by board members and other agency volunteers and agency staff. They undertake efforts to encourage referrals from doctors, hospital social service departments, and other agencies. And some longer-established services find that most of their new recruits come through their present homemaker staff or people who have used homemaker service.

Other means employed to reach the attention of possible homemakers include radio and TV spot announcements and interviews; announcements to churches, prior to training courses, for their bulletins or reading from the pulpit; inclusion in "Welcome Wagon" hostesses' materials; inclusion in literature on adult education opportunities; through the state employment service; and many other channels of communication in a community.

All of these have been found helpful. Both for maintaining a supply of suitable homemakers and also for assuring effective community use of the service, continuing, widespread interpretation of homemaker service has proved essential. In such a program, all the avenues mentioned above, and others, have their special places. One agency reported that the excellent publicity on the launching of its homemaker service itself produced an adequate beginning supply of homemaker applicants.

An important aid to successful recruitment is the establishment of sound, high-standard personnel practices, good working conditions, and employee benefits. These include permanent employment and continued pay during unassigned time, hourly pay for part-time workers which covers travel time to and from their homes, written personnel policies, paid sick leave and holidays, two weeks' paid vacation, Social Security coverage, workmen's compensation, group hospitalization, and a retirement plan.

The status given to the position of the homemaker is also an important factor in attracting the kind of people best suited to the work.

Homemakers should be regarded, and taught to regard themselves, as regular members of the agency staff. Provision of uniforms, emblems, or other means of setting the homemaker apart from a maid or other domestic help also bolsters the worker's pride in the position she holds and the responsibility she brings to her assignments. Formal recognition of completion of training, such as a special ceremony, award of a certificate or pin of recognition, is another aid.

Selection

If formal educational attainment is not a reliable guide to selection of suitable candidates, how does an agency choose applicants? The screening is the responsibility primarily of the homemaker supervisor, but she may have assistance from other professionals, such as casework supervisor, nurse, doctor, or others. Some agencies use a committee of volunteers whose background qualifies them for this. In one agency, where homemakers are included under a merit system, the casework staff was asked to devise a test, not written but carried out in an interview.

More than one speaker mentioned similarities between the recruiting and selection of homemakers and foster home-finding. One warned, "the initial interview with the prospective homemaker is of the utmost importance." Following are one conference participant's comments about this first interview:*

"The arrival of the prospective homemaker for the first interview is interesting to observe. How does she come into the office to greet you? Is she well poised, neat, attractive in appearance? Where does she want to start in the interview? It is best to begin where she wishes to—helping her to explain what she is interested in and why she decided to ask for an appointment. Interpretation of the program can be woven in as the discussion proceeds, depending upon what she inquires about and when. Description of job content easily leads to recall of the applicant's previous employment, if any; from there into education and earlier life experiences. When questioned she may relate incidents which occurred when she cared for one of her parents who was ill or one of her children, or other relatives or friends and neighbors. The picture of her own family begins to emerge as well as relationships with her parents, siblings and own children. Attitudes should be noted, particularly towards illness.

"She decides (or we decide together) whether she wishes to fill out the application form. Is writing and spelling a slow, laborious task for her? It might mean that she had less schooling than she indicated earlier in the interview. This would have a bearing on her ability to fill out the weekly logs and reports, as well as grocery and laundry lists in the home. Reasons for wanting to be a homemaker, as written on the application form, are often revealing. A desire to help people or an interest in performing the service may indicate a woman who would be truly dedicated. The woman who states she wants a job in order to earn money may not be deeply interested in people. The interview usually ends with plans for her to await further word from us after contact with her references. She leaves with literature she can peruse at her leisure at home. Following our interview she has an opportunity to talk informally with the assistant supervisor. The latter explains the method of application for service and converses with her so as to develop a cursory impression of the applicant which is an aid in later evaluation.

"References from relatives are not accepted. Personal references are usually worthless. Who is going to say something detrimental about a per-

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From a paper by Evelyn H. Zeis, Visiting Homemaker Service of Morris County, Morristown, N. J.

sonal friend who is seeking a job? References from doctors and ministers are most helpful. With their understanding of the desirable qualities needed in a homemaker, they analyze the strengths and weaknesses of the applicant. During the interview, an independent reference is sought—some person of good reputation in the community whom we both know but whom she had not intended to use as a reference. Permission to contact this reference is obtained and information gained is carefully weighed. (This was a procedure I used in foster home-finding.) Doctors and ministers are usually reached by telephone, as is also the independent reference. Many observations may be expressed in a telephone conversation that would not be written in a letter. References from previous employment, especially in industry, are requested by letter. If the job content is very different from that of homemaker service, the most helpful aspects of the answer lie in regard to reliability, punctuality and organization of work.

More Than Interview and References May Be Needed

"... Sometimes after a careful evaluation of an applicant's qualifications, there is some doubt as to her desirability as a homemaker. She is allowed to take the training course and observed carefully. Often this clarifies the issue both for her and the agency. Sometimes she withdraws of her own volition, but if she completes the training course, she is placed on the usual three-month probationary period with close supervision.

"Mrs. S is an example of this. Her bluntness during the interview made me question her ability to go into different homes and adapt to various family situations. However, her other qualifications were satisfactory and she wished to take the training course. Observation during the course still left questions and she was placed on her first assignment. Her weekly reports were thorough, observing and tinged with a delightful sense of humor! A letter was received from the family praising her abilities, expressing their heartfelt thanks for having her and mentioning the sense of humor! She has been with us for over two years and has been on a variety of assignments. I may not have been observant enough during the office interviews, but more than likely she was feeling stiff and formal in an office and her performance in a home was quite different.

"This is the point that I want to emphasize. Any amount of office interviews and references cannot take the place of on-the-job performance."

Some agencies use group meetings for the initial screening of applicants. In these, information about the agency and its program, the role of the homemaker in the work of the agency, duties of the homemaker, and other general information are discussed.

The Orientation and On-Going Education Program of a Homemaker-Home Health Aide Service*

Every individual responsible in any way for the operation of a homemaker service—homemakers, members of the governing body, professional and clerical staff, consultants, volunteers—should receive comprehensive orientation on the purpose, function, organization and service objectives of the agency. Orientation should be followed by programs of on-going information and education geared to the developmental needs of the groups involved. Basic guidelines for such procedures are outlined here. It is not intended to describe in detail methods through which these guidelines are to be followed. Emphasis, however, should be placed on the formalized training possible for homemakers through extension or continuing education departments of certain state universities, vocational schools, the adult education and home economics divisions of local school systems and the training programs for homemakers established jointly by public welfare or health and voluntary homemaker agencies in certain communities.

I—Orientation and education of homemakers and all other divisions of staff should include certain basic procedures.

- A. Orientation and on-going education for all staff, with basic training provided for homemakers, should be regarded as a means of developing skills and identification with the agency to help assure the quality of service.
- B. All staff, at every level of homemaker service, should receive planned, purposeful orientation and on-going education for the service to be given. It is desirable that this be done in a group, when possible, to avoid duplication, overlapping or omissions in content.
- C. Education of all staff should be directed and coordinated under one staff member.

II—Orientation and preliminary training of homemakers are important both to the individual employed and to the agency. Orientation should be provided for homemakers with all other members of the staff. No homemaker, either for her own sake or that of the recipient of her service, should be assigned for home duty without orientation to the agency's program and a training period which covers the essentials of the service she must provide.

- A. Orientation information and on-going educational procedures for homemakers should be outlined in a manual. This should include an

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**From STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, published by National Council for Homemaker Services, 1965.*

outline of the content of training, methods of work and duties to be performed. The manual should be made available to each homemaker for continuing reference.

B. Homemakers should have training to provide adequate knowledge and skills as well as the confidence necessary for meeting their job assignments. They should also have job-oriented experience under the supervision of the appropriate staff member of the agency.

C. Homemakers should receive adequate special training where assignments call for special service as with care of children, the aging, the blind, chronically ill or emotionally disturbed individuals.

D. Homemaker agencies which provide personal care for the sick should also provide basic training, individualized instructions, supervision and evaluation of the homemaker's work by a qualified public health nurse.

E. Homemakers should receive periodic refresher courses in the general requirements of home management and in particular areas requiring special skills.

F. Individual needs of homemakers for training and on-going education should be provided through effective developmental procedures and supervision by the agency.

Some Present Patterns of Training*

Patterns of training for homemakers are as varied as a summer garden. Each agency sponsoring homemaker service develops a training program suited to the needs of the service it gives, the characteristics of its candidates for homemaker, the resources available in the community, and other factors. While such variation, reflecting flexibility and adaptation, is desirable, certain principles need to be observed.

Training programs can vary in length, intensity, format, auspices, and other characteristics. But all should be so structured as to preserve economy of time of the workers and staff, and adjust to availability of consultants and trainers, as well as meet the particular needs of the community for service. In addition to any specialized content, it is essential, of course, that the training include what the agency's purpose and program objectives are. And it should encompass overall concepts about the homemaker service program

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Excerpt from REPORT OF THE 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES, published by National Council on Homemaker Services, 1965.

and its philosophy. Obviously, training should be directed specifically to the homemakers in the particular agency in which they are employed.

A new resource for provision of training for homemakers is offered through the Manpower Training and Development program. This makes Federal aid available to train homemakers and thus open a satisfying career to older women whose own families have grown.

Many feel that all homemakers in a program should have the same basic training. Then, as experience provides clues to the interest and aptitude of certain homemakers for work with particular groups of people (or types of situations), provision can be made for more specialized training in these specific areas.

Minimum basic content needs to be taught quickly and early in the prospective homemaker's contact with the agency. Agencies are warned against over-training and under-utilizing workers.

It is not possible in this report to describe all the numerous training program plans which were discussed at the conference. A few will give some idea of the variety of patterns now being followed.

In some limited programs involving only a few homemakers, training is given individually in homes served. This follows a conference with the homemaker to provide general orientation. To this, some agencies add periodic group discussions. In these, homemakers can discuss with each other and the supervisor problems they encounter in their work. Training consultants from various professional fields may be brought into these sessions for discussion of specific areas, such as budgeting, child behavior, and psychology of the aged.

Consultants from Various Fields Used in Training

Involvement of consultants from various professional fields such as medicine, nursing, home economics, psychiatry, psychology, casework, first aid, safety, physical and occupational therapy, and others in training programs is common.

In some areas, several agencies offering homemaker service combine their training efforts so as to benefit to the fullest from the availability of various professional experts. Movies on family and child problems are a teaching aid sometimes used.

Maximum use of resources outside the agency for training of homemakers is also employed to reduce costs of training. One training course, co-sponsored with the public school department of adult education, has 17 different instructors from public and private health and welfare agencies and the medical society. Another, in a state mental hospital, is given by the homemaker supervisor, the hospital social worker, psychologist, psychiatric nurse, and home economist. It is followed by monthly group supervision programs.

In another, the state university's extension division, working with the state health department, supervises a homemaker training course offered throughout the state. Each homemaker service determines when it wants the course and applies for it to the state health department. It is offered in the county of the homemaker service and taught by local people. The homemaker service director gives each instructor a short orientation to homemaker service and what a typical homemaker is like. This is a 22-hour course and is considered an orientation only, to be supplemented by on-the-job training, monthly meetings, and specialized seminars.

Some indication of the variances of scheduling and length of training programs is demonstrated by these few random examples: a six-week, 96-hour course; an eight-week course of two hours a week; a 10-day course consisting of four hours each morning; a course of 20 to 22 hours in either a one-week or two-week period; informal monthly two-hour evening sessions.

In many agencies which emphasize the team approach, the homemaker's participation in staff discussion of individual case situations is an additional training experience. Other agencies use periodic evaluation, especially in the early part of the homemaker's service, as a means of increasing knowledge and upgrading performance.

A Formalized Homemaker Training Program*

by Elizabeth Burford
Child and Family Services
Chicago, Ill.

After 32 years of providing homemaker service for families with children in the Chicago area, the Child and Family Services agency is expanding its homemaker service program in two ways. First, the geographic area is to be enlarged by establishing district offices in three widely separated suburban areas, from which locally provided services can be offered by homemakers living in the local areas, supervised by caseworkers operating from the district offices. Second, the homemaker service program in the suburban areas is to be extended to include services to aged and chronically ill clients, as well as to families with children.

A fundamental requirement for such a program is a staff of trained homemakers who differ markedly from domestics or housekeepers in terms

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of skill and knowledge. At the time of their employment, our new homemakers are expected to have sufficient intelligence to learn, to be adequately trained in "the three R's," and to have demonstrated successfully their ability to give child care and household management in normal situations in their own homes or in domestic service. Agency homemakers, however, work in disrupted homes with people who are undergoing crisis and in other situations that are not normal. They must therefore learn how to understand these people, how to function under such circumstances, and how to work as staff members of an agency which is trying to help people in trouble. To accomplish the difficult tasks involved in being an agency homemaker, they need specialized training that will develop their knowledge, self-control and objectivity.

In an effort to maintain a high standard, both in continuing the city-wide service and in meeting the new and increased demands of the expanded program, the agency has decided to examine its present homemaker service program in order to formalize, in writing, what we are doing to train homemakers, and to examine the content and methods of our training program in the light of what our particular homemakers need to know and do.

Method Outlined

Our formalized homemaker training program is divided into two parts: the orientation of new homemakers and the in-service training of experienced staff. Each of these parts is divided according to the method of training. Orientation is provided through a standard course of instruction given at the office by the homemaker supervisor and through observation of experienced homemakers on the job. In-service training is provided through individual supervision by the caseworker responsible for each assignment, through group training courses, and through the instruction of individual homemakers for special assignments.

Content Described

A standard "Orientation Course for Homemakers," in written form, was prepared and used with all homemakers employed since January 1961. It includes information about the agency, its history, organization, personnel, and program. Homemaker Service Department procedures are presented in detail. A copy of homemaker personnel policies is given to each homemaker, and each has an opportunity for questions and explanations. A discussion of the homemaker's duties and responsibilities is based upon written material, "The Homemaker on the Job," which is gvien to the homemaker to keep for reference.

Other topics of instruction and discussion are: the meaning of supervision, the relationship between the homemaker and the caseworker, and evaluations and classifications of homemakers. The climax of the course is a discussion of what professional behavior involves and what is expected of a staff member of a professional agency in such areas as preserving confidentiality, maintaining self-control, avoiding a personalized relationship with families, and the need to grow in learning and in self-understanding.

In connection with this orientation course, written materials, including *Baby and Child Care* by Dr. Spock; various publications by the Department of Health, Education and Welfare (Children's Bureau) on *Infant Care, Your Child from One to Six, Your Child from Six to Ten,* and *The Adolescent in Your Family;* certain pamphlets published by the agency for publicity purposes and for reports; and the pamphlet *Introducing Your Homemaker,* are given to the homemakers.

Field Work: an Experiment

Field work observation of experienced homemakers on the job was a challenging and experimental method of teaching new homemakers that helped solve some of the problems entailed in employing non-professional staff in a teaching capacity. In order to exercise as much control as possible, we selected five Class III homemakers[**] for instruction in demonstration. These five selected homemakers met in two seminar-type sessions with the homemaker supervisor. They were encouraged to regard this as a great responsibility and honor and to think of it as an opportunity to show the best performance possible. They were instructed in answering simple questions relating to the activities which were being demonstrated, and in referring more complex questions, usually questions concerning agency policies and procedures, to the supervisor.

In implementing this field work observation, it was necessary to obtain consent and cooperation from the families where the demonstrating Class III homemakers were working. We tried to choose those situations which would teach the new homemaker something about the diversity of the agency's program. Before each day of field work observation, the new homemaker came into the office to learn from the caseworker such things about the family she was going to observe as the reason a homemaker was there, what a homemaker was trying to accomplish, and what special things she was to observe. During her day of observation, the new homemaker worked with and under the direction of the experienced homemaker, helping her but keeping her own eyes and ears open. Immediately following this observation day, the new homemaker returned to the office to discuss with the caseworker or the homemaker supervisor what she had seen and heard, and to get answers to her questions. Every new homemaker had between two and five days of observation, with a new situation each day.

[**] *Our homemakers, like caseworkers, are classified according to their job performance. The most competent homemakers are in Class III.*

Evaluating this experience, we have concluded that field work observation, if used with discrimination and with as much control of the entire experience as possible, represents a quick and vivid teaching device. Reactions of new homemakers were usually around the theme: "I had not realized how hard," or "how demanding," or "how challenging," or "how interesting the job is." It provided for them a frame of reference within which the orientation course took on richer meaning. It gave new homemakers a much better conception of what they were expected to do. All of the families cooperated and all of the demonstrations appear to have been very well carried out. The experienced homemakers felt challenged to do a good job and expressed pride in being allowed to share in helping the new homemakers. Some of the observations of the new homemakers were astute and valuable.

Each Class III homemaker who demonstrated was asked to report her experience and gave observations regarding such things as the new homemaker's ability to care for an infant, her ease with children of different ages, her reaction to discipline problems, her competence in some household tasks, and the children's responses to the new homemaker. In one family an accident to one of the children required the experienced homemaker to take that child to a doctor, leaving the new homemaker at home with the other children. We learned much about the new homemaker from the report of how she met and managed this emergency.

In-Service Training Improved

The in-service training of experienced homemakers has traditionally been accomplished through individual supervision by caseworkers and group courses and discussions. These methods are not new. We tried, however, in our formalized teaching program, to enrich the content of each method. In order to help caseworkers give individual supervision in a way which would develop each homemaker's potential most effectively, the homemaker supervisor prepared a written diagnostic evaluation of each homemaker, concluding with a statement concerning the type of supervision needed by each. For example, some homemakers need support, some need control, some need to limit their involvement. Each homemaker has strengths and weaknesses which need to be known by the caseworker who is to help her function most effectively.

Caseworkers were expected to read these evaluations and to use the knowledge thus gained in more effective individual supervision of each homemaker. Caseworkers were expected to keep the homemaker supervisor informed of the homemaker's response to supervision so that the supervisor could involve the homemaker in further training in areas where it was needed. This type of homemaker supervision—thoughtful, individualized, and positive in purpose— approached the professional supervision that caseworkers receive and played an important role in upgrading and professionalizing the position of the homemaker.

Group training courses will always depend, for their content, on what the agency wants its homemakers to know and what resources are available for training. We wanted our homemakers to know about child care, and so we provided a four-session course on "Child Development," given by our psychiatric consultant. Because our agency has many situations where the mother is emotionally ill, we provided a course on "Understanding the Emotionally Ill Mother," also presented by our agency's psychiatric consultant in two group sessions. Utilizing community resources outside the agency, we arranged for our homemakers to receive instruction in "Care of the Sick," the standard Red Cross home nursing course, as well as a course in the demonstration kitchen of a local cooperative, on the subject, "Well-Balanced, Low-Cost Meals." This course, particularly adapted to agency homemaker needs, was given by a home economist. All the group courses included in our formalized homemaker training program will be offered to the homemakers to be employed in our suburban district offices. Also, in order to train new staff for a program which will be expanded to include service to the older person, these homemakers will be given a new course, "The Older Person, His Physical and Emotional Needs."

School of Social Work Gives Course

Highlighting our agency's effort toward helping the homemaker provide the best possible service for her families was a homemaker training course given under the auspices of the University of Illinois School of Social Work. To our knowledge, this was the only such course in the country given at a school of social work.

The course was planned by a curriculum committee that included representatives from the Welfare Council of Metropolitan Chicago, the University's School of Social Work, and staff members of four welfare agencies which participated by sending their homemakers to the course. The committee agreed that the course should be designed primarily to cover the "human relations" aspects of homemaker service, containing, according to the official course description, discussions leading to a fuller understanding of such things as "the meaning of family life, the various usual responsibilities of all the people in the family, how they get along with each other, what they expect of each other, what problems they face, and how they work with their problems." Proceeding from there, the description continues, the course will move to giving "more particular attention to the effects of strain on members of the family, and how they are to be understood and helped by the homemaker and the agency during periods of care. The focus will be on how homemakers use this information."

Presented four times in eight weekly two-hour sessions on the campus of the University of Illinois School of Social Work, the course was offered to homemakers from four Chicago agencies, thus affording the homemakers an opportunity to exchange the views and teachings of their respective agencies and broaden their view of the field of homemaker service. A registration fee for each homemaker was paid by the agency, and the homemaker herself was paid at the regular rate for her time while taking the course. The instructors were Dr. Maria Piers, a lecturer on the faculty of the University of Illinois School of Social Work in the "Dynamics of Human Development," and Mrs. Frieda Engel, lecturer in social casework and agency consultant. The report by the University of Illinois School of Social Work, at the conclusion of this course, listed the following topics discussed: What Does Family Life Mean? What Happens to a Family When Mother Is Gone? What Does the Father's Absence Do to a Family? The Effect on a Family of Diminished Income, Temporary Absence, Death, Desertion, Divorce, or Illness; What Does the Homemaker Do for the Family Concretely? How Much Can a Homemaker Do About Cleanliness and Order? What Can a Homemaker Do When Children Will Not Obey? Teenagers in the House; Explaining Things to Children—Talking About Difficult Subjects; Older People and Their Care; The Feelings of the Homemaker.

An evaluation of this course stated: "The prime value of the course lay in the homemakers' changing attitudes toward their own human relationships . . . the homemakers gave evidence of an increase in empathy even towards clients of whom they disapproved . . . additional perspectives on human behavior were gained through recognition that there were reasons and explanations for clients' actions . . . and that knowledgeable approaches were open to them. Homemakers demonstrated motivation and interest in deepening their understanding of their client group and a readiness to use resources of the agency caseworker and supervisor in fuller exploration of the significance of behavior in each particular case."

At the conclusion of the course, a certificate was given to each homemaker in recognition of the significance of having been enrolled in a course under university auspices. This appeared most important to them.

Other Resources Used

In addition to all of the group courses, the formalized training program included single group meetings for the presentation of audio-visual materials. The film "Home Again" and the slide series "Anybody's Crisis" were presented to the homemakers. Occasional staff meetings were included in the formalized training program because we considered it a part of in-service training for homemakers, as well as all other staff members, to be informed of certain agency administrative matters.

As part of the training program, the agency also arranged for instruction of individual homemakers for special assignments. One homemaker was sent to spend two days at a research hospital, learning how to adjust braces and

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use mechanical equipment to care for a totally paralyzed mother who was returning home; another was sent to an institute for parents of blind children, conducted by the Illinois State School for the Blind, in order that she might learn how to care for blind children. Several homemakers helping mothers on restricted activity were instructed in the use of labor-saving devices at the "Cardiac Kitchen" located at a Chicago hospital. In providing such specialized instruction, community resources outside of the agency were used, with any necessary financing provided by the agency. Homemakers thus trained became more valuable staff members.

Summary

Thus, although homemaker training programs will differ with agency needs and training resources will vary from one community to another, our experience has shown that agencies, whatever the resources may be, can benefit from a formalized homemaker training program.

As a result of our experience in planning a comprehensive training program for homemakers we have been able to fill gaps in content and to develop the training with consistency and continuity. We believe that we are now able to present our program to the community, with confidence in the fact that our homemaker staff is equipped to give the service offered. We believe also that we have sharpened our concept of what homemakers must learn in order to meet the needs of our homemaker service program, and that having done so has helped us develop a sharper diagnostic sense for recruitment of homemaker staffs. Communication and the teamwork relationship between homemakers and caseworkers have likewise improved as we clearly defined what could be expected of homemakers. Formalization is the first step toward standardization of homemaker training, which helps to create a recognized professionalized position for agency homemakers.

Recruitment and Training of Homemaker-Home Health Aides*

by Brahna Trager
Executive Director
San Francisco Homemaker Service

We have been hearing a good deal lately about homemaker service and its offshoot, home health aide service. Here in the United States it is the johnny-come-lately of the range of in-home services in the medical

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care field, and what we do hear depends a good deal on where we happen to be. From the family agency we hear that the homemaker is a kind of fairy godmother who, with miraculous skill, fortitude and understanding manages to keep the family intact, no matter what the circumstances may be—poverty, disease, abandonment, alcoholism—and, to reduce things to reality a bit—during maternity hospitalization and other long or short-term family crises "in the absence of the normal homemaker."

There Are Many Myths About Homemakers

From the generalized homemaker program (such as the one I represent), which is oriented to chronic illness, disability and aging, we hear that the homemaker or home health aide prevents or eliminates the need for institutional care; that she can replace relatives, nurses, housekeepers and social workers—and again, more realistically, that she can be a sustainer of the plan for the patient at home—provided it is a good one.

From private physicians, some hospitals and even some home care programs, we hear that the supervised homemaker or home health aide is a fancy, over-priced, over-trained, over-supervised character who is unnecessary since "anybody can do simple housework, give a bath or even do a few nursing procedures," and what is needed is just the nearest employment office.

And, more recently, we have been hearing about the homemaker as a teacher in the home who rehabilitates the normal homemaker. We are also hearing about homemaker and home health aide service as a fruitful solution in the poverty program; it is to be used to take women off the relief rolls by training them in large numbers to become professional homemakers. Here it appears that the program will be geared to the needs of the employee rather than to those of the consumer of service.

Variety of Titles Is Confusing

There is an equal amount of confusion when we try to make our way through the variously titled groups of helpers in the home these days. As a worker in the field, I am hard put at times to explain to the uninitiated the precise difference between a homemaker and a housekeeper; between a homemaker and a home health aide; between a home health aide and an attendant; between an attendant and a practical nurse and so on, through a whole range of sub-professional groups of workers who are being used in one way or another in connection with the care of the sick at home.

This multiplication troubles me for several reasons. The least important, from my point of view, is that we are going to be wasting a good deal of time defining function, establishing criteria for selection, setting up specialized training programs which differ from one another slightly but in which those slight differences are going to become important to the people who set them up. The most crucial reason, from my point of view, is that we are in danger of seeing further fragmentation in what is already a somewhat chopped up picture when we look at services for the chronically ill.

It is important to decide what kind of service we want, if we are to make some general statements about the preparation of the people who are to provide that service. And general statements are difficult if, of the 25 or more participants in this workshop, you are each thinking through the range of, "just the housework," to "why *not* give insulin—we teach family members to do it." I am going to try to generalize in an area between those two extremes in order to develop, if possible, an understanding of what a group of well-selected, well-trained and properly supervised women (and men, too, occasionally) can do to sustain a plan for the care of the sick at home.

It seems to me that there are two common denominators that we can establish as a guide to the recruitment and training of these people. The first is that the service is provided at home. The second is that it is provided where illness, usually chronic, is the focus of our concern.

The Situation Is Never Simple

Now it may seem to be a fairly simple business to send someone into the home to keep things going. It usually is, in a normal situation. In a normal situation, of course, one could simply call the nearest employment agency and hire a day worker. But in-home services are not provided in the normal situation. Illness brings with it, as we know, a whole range of associated problems: emotional, financial and environmental; and for the individual who is ill, and for his family, the stranger who comes into his home, to be associated with him in the most intimate way and on a continuing basis, can either be a great source of strength or an enormous irritation. The doctor comes and goes; so does the nurse; so does the social worker. If they seem cold or kind there is an interval between visits and new approaches to the relationship can be made. But the homemaker or aide who sings at her work all day, day in and day out, when song is not appreciated; who never talks, or talks too much, or is "bossy" or who cooks the same thing every day, or who doesn't cook the same thing every day—can be an inescapable source of misery—acute because her services are needed whether she is irritating or not.

In brochures that are coming from most homemaker programs today we hear these women described as "mature, flexible, adaptable." Now how does one go about recruiting a "mature, flexible, adaptable" woman so that her services will be appreciated in the home of a cardiac who is compulsive about cleanliness and who can never be satisfied that someone else can do things properly—and so that she will be equally appreciated in the home of a social arthritic who wants conversation as a substitute for lost mobility?

The answer to that question, of course, is that it is not possible to find such women. We can and do find women with certain personality traits.

The rest must be provided by the agency as a part of a program of continuous training.

What we look for in our first interviews is primarily an attitude. We are wary of the person who "just *loves* to help people!"—because that eagerness often becomes an unhealthy involvement. We are wary of the women who "always wanted to be a nurse," for even more obvious reasons (although we have occasionally been able to channel that interest constructively). It is the woman, young or old, educated or uneducated, who has a kind of smiling calmness; who seems to take pleasure in putting good food on the table; who seems to enjoy the idea of making a clean, serene environment; who does not appear to be defensive; who can, as social workers say, "relate" to people—she is the one we try to find for this service. Once she is found, we are committed to a rather large investment in the way of training.

First of all, we make every effort to build in her a strong sense of identification with the agency and its purposes. Regularly, three or four times a year, our women are brought into the office in small groups and, together, we review the policies of the agency and the reasons for these policies. They learn that they must be punctual, not because they are wasting time and money, but because sick people often cannot bear to wait and become apprehensive after even a few minutes of waiting. They learn that they must never argue, no matter how unbearable the situation becomes, because argument may mean one thing to them and another to the patient. But they are told that they can call the office and complain long and loudly about an unfair situation and that we will listen with sympathy and patience. They are encouraged to call or to come into the office whenever they have the slightest doubt, the slightest question about any family, any situation. If they are asked to do something that is not in the rules, they are taught to say "I will call my office," and they know that one of *us* will take the responsibility for difficult explanations. They are never sent into a home without a description of what they will find and an explanation of what they are to do.

They Learn to Be Observant

We ask our women to be good observers, to try to notice whether people want to be talked to or whether they would rather be left quiet, and we often help them to decide this. We discuss with them ways in which they may approach families in different circumstances and we keep them firmly out of concerns with the financing of care or people's financial circumstances. We do ask them to be careful if they notice that people must manage their money carefully. We ask them to notice changes in emotional tone, in physical well-being or deterioration, and to let us know if, for some reason, they sense that things are not going well. We do not use them in any kind of authoritative way. They are not required to prevent an alcoholic from drinking or a patient with chest disease from smoking. Where the drinking and the smoking are going on, the homemaker does keep us informed but, in our work with the family, every effort is made to keep the homemaker free of the kind of entanglement which would make her a spy in someone's home. Her attitude is always that she works in the home of the family to serve that family and that we are there in order to help her do it as well as possible.

In the course of her work she will, we hope, develop a strong relationship with her supervisor—one in which she feels quite free to suggest as well as report—and one in which she will always be able to be frank about her misgivings as well as her achievements.

We have found that this kind of training is probably the most productive, but we do provide formal training as well.

I spoke before of the dangers of over-specialization in this field and I have often thought that the people who dream up various categories of services to be provided by different and specially trained people are perhaps removed from the realities, considerably removed. We have found that the person who needs to be cared for at home rarely needs care that is static. In the beginning, we tried to stay out of personal care and to confine our women to such tasks as household maintenance, shopping, cooking, the preparation of special diets and the provision of comfort and security in personal interaction. We thought that, if personal care of any kind was needed, it should be provided in some other way. I think we made a distinction, or tried to, between managing the environment and touching the patient and we thought that touching the patient was a "nursing function."

We found, however, that the patient who was able to get up and dress one day, needed help in dressing and going from bed to chair the next. We had innumerable telephone calls from our women about the patient who had bathed herself for weeks, but who was now sitting in the bathtub and couldn't get out without help, or the patient who had not needed help in walking before but now must remain in her chair unless she could be helped. We found that, in chronic illness, change is the order of the day, and that it was not practical, not even possible, to have a helping person in the home who could not help in situations such as these. Our decision to use our women flexibly, to eliminate shifts in staff or the addition of specialized personnel for such tasks meant that we must train our women to perform safely in situations where personal care was required, either occasionally or regularly.

Simultaneously, Federal regulations in the public assistance program described a kind of in-home personnel which was called the "home health aide" and authorized the purchase of such services for recipients of assistance.

Standardized Training Program Developed

In our state, the decision was made that standardized training should be provided for such personnel and a committee, composed of representatives from various programs providing home care, homemaker service, rehabilitation services, as well as from the various professions involved in medical care, developed a program consisting of 120 hours of training. Upon satisfactory completion of this training, a certificate entitled the trainee to function as a home health aide; the committee recommended that this should be under professional supervision and, further, that such aides should be reimbursed from public funds only if they were employed in a recognized agency.

This course is given several times each year by our adult education program in a large chronic disease hospital and we have been sending our women to school after they have been with us for awhile and we are satisfied that they will work out well.

Briefly, the curriculum is as follows:

> Approximately 50 per cent of the time is spent in the development of skills relating to personal services. A good deal of emphasis is placed upon hygienic care such as grooming of hair, skin, nails; shaving, dressing and care of the mouth and teeth; upon moving activities, such as helping the patient in and out of bed, chair, toilet or commode, tub and shower; and carrying out the medical plan through exercise, positioning, assisting in walking (with and without devices) and promoting self-care activities.*
>
> About 25 per cent of the time is spent in teaching basic principles of nutrition, cultural and economic backgrounds, meal planning and serving, food purchasing, food preparation, sanitation and storage, and the preparation of special diets.
>
> About 10 per cent of the time is spent on cleaning and care tasks in the home with emphasis on home safety measures, sanitation and the economical management of the environment.
>
> Fifteen per cent of the time is spent in developing some understanding of the community agency relationships and basic concepts of human development and behavior. In this section, emphasis is also placed on relationships with professional personnel such as physician, nurse, social worker and some very brief time is spent in discussion of common medical problems and the implications of long-term illness, ethics and confidentiality.

We have found that this training has been the most helpful in those aspects related to personal care. It has not taken the place of regular training sessions which we still provide and which relate mainly to people as individuals. The on-going program which makes for a real helping personality in the home is the one which develops understanding of why people behave as they do; how people can be helped; why they sometimes can't; what

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******Obviously, appropriate health personnel—public health nurse, physical therapist or physician—gives specific instruction for the care of each patient and continuing supervision of these activities on the part of the homemaker, as indicated in each situation.*

people do with their anger, their sorrow; what despair can do; what hope can do.

Out of this training we have added to the constellation of in-home services a source of strength—a person who has warmth as well as detachment, humor as well as sympathy, observant eyes and ears; and, in addition, is capable of providing good nutrition, a clean house and personal care.

It may seem that the millenium has come for the patient at home and, at the risk of destroying that pleasant thought, I would like to stress some rather important considerations:

> It is not safe to keep a person at home who belongs in an institution.
>
> It is not even cheaper to do this and I hope we will all stop saying that it is.
>
> It is not possible to build constructive in-home services around an impossible home situation; I mean impossible because of poverty with its associated bad housing, inadequate nutrition and general deprivation.
>
> It is not possible to provide homemaker or home health aide services constructively without the whole range of medical and social services necessary to good home care.
>
> It is not possible to provide homemaker-home health aide services at all without adequate financing.

Supervision of Homemakers*

The supervisor of a homemaker program has an important role to play in the agency's operation. She is responsible for the effective performance of the homemakers and serves as liaison between the executive, the professional staff responsible for the service plan and the homemaker. The supervisor should have the qualifications and certifications of his professional field and considerable knowledge of administrative functions.

1. The supervisor of a homemaker service should be selected from a professional group identified with particular goals of homemaker service and should have the appropriate qualifications and certifications related to his field. Traditionally, this has been the field of social work, home economics or public health nursing.

**Excerpt from STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, published by National Council for Homemaker Services, 1965.*

2. The supervisor should have had sufficient practical administrative experience in an appropriate professional setting to carry the rigorous responsibility necessary in a homemaker service.
3. The supervisor should be able to plan and carry out a program of orientation, training, assignment to jobs and continued supervision of homemakers employed by the agency.
4. The supervisor should interpret to the employed homemakers their role and responsibilities both in regard to the agency which employs them and to the families they will serve.
5. The supervisor should evaluate periodically the homemakers' job performances.
6. The supervisor should maintain effective relationships and liaison between professional staff of the agency and the employed homemakers.
7. The supervisor should recognize when consultation with a professional discipline not generally involved in the agency's program would enrich the service to recipients and secure such help at the appropriate time and in adequate amounts.
8. The supervisor should utilize volunteers where such help would be productive and provide necessary auxiliary personnel.

Essential Ingredients of Supervision[*]

The necessity for professional supervision of homemakers is a principle of successful homemaker service generally subscribed to by those attending the conference. As might be expected, there was difference of opinion as to whether the professional supervisor should be from the casework or nursing fields, depending on whether the service was sponsored by a welfare or health agency. In at least two conference papers, however, programs were described which are under health agency auspices but use a trained caseworker to supervise the homemaker program. In both cases, the agency representative speaking at the conference endorsed this arrangement. One stated that the nurses in the agency (a health center) are so impressed with the advantages of casework service that they would like to obtain additional funds so that more caseworkers could be added to the staff.

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[*] *Excerpt from REPORT OF THE 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES, published by National Council for Homemaker Services, 1965.*

In addition to initial interviewing and screening of homemaker applicants, the homemaker supervisor is responsible for coordination of the training program. This person also makes the selection of individual homemakers for placement, matching the special abilities and qualities of a homemaker to the specific requirements of an individual or family needing service. The organization of a homemaker's assignments, where assigned on a part-time basis (with due regard for distances between assignments, time factors, comparative urgency of situations needing service and availability of service), is the supervisor's job, too. The supervisor is responsible for deciding, in consultation with the caseworker, nurse or other professional person involved in a situation, on the duties to be performed by the homemaker, hours to be worked and date service will begin. Termination of service is also worked out by consultation between them.

It was suggested by two or three conference participants that about eight to 10 homemakers should be the maximum number assigned to one supervisor. In some agencies, regular supervisory interviews with homemakers are scheduled, as well as participation in agency staff meetings. Homemakers are also encouraged to confer with the supervisor either in the office or the home being served, or by telephone, whenever they encounter any problems or questions in their work.

Gives Her Sense of Security

This relationship with the supervisor not only stimulates learning, but also gives the homemaker a sense of security which leads to more efficient functioning. The homemaker should feel secure enough to report to her supervisor whenever, for any reason, she cannot or does not wish to carry out a particular assignment. The supervisor's availability to homemaker staff, even in the evening or early morning, is important to their security in their jobs, or for guidance in working out their own problems on their jobs.

"Supervision of homemakers involves the use creatively of skills of administration, education, direct service and community organization," observed one participant. Constant interpretation to the board and staff of the agency, cooperating agencies and community are part of the homemaker supervisor's function.

The homemaker must also be helped to understand her role in a given assignment, according to the family's need and the long-range goal of treatment. She needs to understand, in each situation she goes into, what part she is expected to play. She should have a clear answer from her supervisor to one or more questions like these:

Is the homemaker a temporary substitute for the mother who is absent from the home? Is she the mother's teacher-companion-housekeeper during convalescence? Is she the daughter substitute for an aging couple or individual? Is she working with other assistance in the home—nurse, nurse's aide? Is the service needed because of a crisis in the family's pattern of living? Is it a protective situation? Is it a "holding" operation until the family can mobilize its resources or accept placement of the children or other members of the family, or adjust to the loss of the patient?

Responsibilities of the supervisor in relation to direct service also include:

Conference with the staff members responsible for the on-going treatment plan and how they see the role of the homemaker and the plan of supervision; timing of home visits; office hours when the supervisor can be reached by the homemaker; office consultation with the homemaker;

Preparation of the homemaker to meet the needs as presently evaluated, such as a home visit prior to assignment (if time permits) to meet the mother, children, the father, and other members of the family who may be sharing responsibilities during the period the homemaker is in the home; learning special routines of the family's pattern and standard of living;

Homemaker's relationship to the supervisor of the service. The responsibilities each assumes in the assignment should be clearly delineated since it is the source of support to the homemaker.

Evaluation Is Important Element

Evaluation of the performance of individual homemakers is an essential element of the homemaker supervisor's overall administrative-supervisory responsibility. The educational component of the evaluation process cannot be over-emphasized since, in the final analysis, the primary purpose of evaluating homemaker performance is to assure quality service.

Informal evaluations usually occur during all cases accepted for service. In some instances home visits are made by the homemaker supervisor. In others the caseworker, nurse or other professional person making frequent contact with the home shares information with the homemaker supervisor.

These home visits provide an opportunity to observe physical changes which have taken place as a result of the homemaker's assignment. The relationship between the homemaker and family is observed, with particular attention given to sensitive areas in the relationship. For example, how well is the homemaker able to support an inadequate mother who must be taught to improve home and child care practices, but whose role as parent must be maintained? Or how does the homemaker handle bed-wetting or other disruptive behavior of children suddenly deprived of a parent? Or how well is she able to relate positively to the emotional dependence of some aged adults? Observations in these areas made directly by the homemaker supervisor herself, or related to her by other professional staff, add considerably to her understanding of strengths as well as problem areas in the homemaker's performance.

Regular office conferences between the homemaker and homemaker supervisor also are a means of evaluation. Here the homemaker discusses problems and difficulties in the assignment. What problems does she select for discussion? Is it a realistic problem? What attempts has she made to work through difficulties independently with the family? What help does she ask of the supervisor? Is this appropriate? Does the problem reflect lack of knowledge or skill? Does it reflect difficulties in the homemaker's relationship with the family? What modification of the assignment does she suggest? This kind of interchange between homemaker and supervisor allows each to assess the performance of the homemaker in a non-threatening constructive way.

"Termination of service" conferences involving the homemaker, homemaker supervisor, caseworker, nurse, doctor and other agency staff concerned with a particular family are another means of informal evaluation during which an assessment is made of the role of the homemaker in carrying out the goals of the service. Such conferences are not held routinely but are usually limited to cases where the homemaker's role is crucial to the preventive or therapeutic aims of the service.

These informal evaluations, in addition to the homemaker's participation in group meetings, help the agency to identify particular skills of the homemaker which warrant her assignment to specific kinds of family situations.

Most agencies formally evaluate homemaker performance at certain time intervals. Such evaluations are required of agencies employing homemakers under state merit systems. Regardless of whether this is a merit system requirement, the homemaker and the agency need the opportunity of assessing, jointly, the homemaker's areas of skill and of planning for the help she needs to improve performance through supervision or in-service training.

Supervision and the Homemaker-Health Aide*

by Catherine Williams
Staff Development
State Department of Social Services
Des Moines, Iowa

Supervision is a three-dimensional function: administration, teaching and evaluation.

In each of the three areas, there are several sub-headings which, when combined, add up to a rather imposing list of responsibilities for any one

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**Excerpts from paper given at Training Conference for Directors and Supervisors of Homemaker-Health Aides, February 20-22, 1968, Ames, Iowa.*

person. However, the one comforting and reassuring factor is that if a supervisor is appropriately executing her functions, she will have support, for there should be a team approach which insures a collaborative relationship when homemaker-health aide services are being used.

"Homemaker service does not result merely from the assignment of a homemaker to a family or individual situation. It derives from the coordinated efforts of the homemaker supervisor, homemaker, caseworker, physician, nurse, physical or occupational therapist who may be involved in the client's total plan of care."[**]

Administration

In traditional terms, administration means transference of policy into practice. Function is a means of transferring policies into practice, through recruiting, training, and placing staff where the supervisor's service is needed.

This pre-supposes a certain knowledge of operational factors:

1. Type of care-cases most frequently requesting help
2. Knowledge of human psychology, as a base for understanding motivation, both of client and staff
3. Knowledge of areas of strength in those on staff
4. Knowledge of kinds of training content needed for the effective and appropriate use of the above.

It pre-supposes also a systematic and efficient organization of the supervisor's work, including:

1. A file of application requests, as to type of care needed—sources of referral
2. Case files of homemaker-health aides—personnel, progress reports and evaluations
3. Inventory of statistical information kept current
4. Organization and processing of work plans, time sheets, financial data
5. Appropriate use of clerical staff to free the supervisor from simple record keeping so that she may devote more time to training and administration.

Efficient organization also includes a plan for feed-back to the administrator, who will use the supervisor's organizational data, the required statistics and reports, to evaluate the program. Consultation with agency colleagues or departments is needed to effect a smooth operation.

Interpretation, as a part of the job, means that there should be a great many different kinds of information about the caseloads assigned to the homemaker-health aides.

[**] *From "Guides for the Administration of Homemaker Service in Public Assistance Programs," State Letter #910 issued July 8, 1966 by Director, Bureau of Family Services, Welfare Administration, U.S. Department of Health, Education, and Welfare.*

An important part of the responsibility is community interpretation. Community acceptance is gained through workers' performance. Nothing sells a service more than the demonstration by doing. Word-of-mouth will reach many who yet need to be convinced that the service is necessary. Testimonials of families served will be the most significant reference and recommendation. Collaboration with other community agencies also helps to interpret the service.

Authority

The role of supervisor has certain lines of authority. Her responsibility is related to her functions. It is not the caseworker's, the line supervisor's, the physician's or the nurse's, but her particular role which carries with it the above-mentioned functions.

She must learn to be comfortable with this authority and to carry it effectively. Her competence will grow out of her knowledge and demonstrated ability to do the job.

Teaching

It is the agency's responsibility to determine the content of the training which is needed to perform this job. If this is the responsibility of the administrator, then the supervisor will need to know the material for several reasons:

1. To be comfortable in her supervision
2. To know how to follow up the training
3. To be able to hold workers accountable for performance
4. To evaluate on the basis of where the worker should be in terms of her training.

Two ways in which training may facilitate learning may be:

1. In individual conferences
    a. Use of case records
    b. Observations by the homemaker-health aide which add to knowledge; observations which are interpreted in terms of their significance to family functioning, and as diagnostic clues to future service
    c. Support of the homemaker-health aide when problems are pressing, enabling her to express any frustrations.

Ellen Winston, former U.S. Commissioner of Welfare, has stated that one of the supervisor's responsibilities is to "increase sensitivity to the less tangible needs of the client—as a member of the team, to give moral support, the homemaker-health aide must be helped to see her role as mother-substitute to children (in many cases), as a companion for the elderly, as a teacher for parents and older children.

"Therefore, as part of the administrative assignment, the supervisor through the teaching evaluation is able to make thoughtful job placements, taking into consideration particular aptitudes and skills, the needs of the family, and the responsibility for being accountable for the level of service given."

Coordination, Cooperation and Communication

Coordination of any family plan involves the referral source, the family, and the team member who is to help manage the plan. Timing of implementation of service is important to the final result, bringing all the team along when the plan is modified and, evaluating as a team, the service at termination. Coordination should define areas of responsibility; and, if any member of the team becomes involved in the responsibility of another, this should be a matter of team consideration.

Cooperation—By common consent, in the best interest of the family to be served, the emphasis of a service plan may be more the responsibility of one team member than another at any point. Enabling attitudes of recognition of the need to become inactive for a time will make the total task easier for all.

In some instances, one team member might feel that her responsibility is exceeding the plan of service. A supervisor might need to interpret this to a caseworker, or homemaker-health aide, or with either supervisor. One sure way to engender enabling attitudes is to consult together, talk over the problem together as a team, and come to some common agreement on responsibilities.

Communication—Sometimes the right hand of service does not know what the left is doing. If so, the adage is applicable. Frequently, the breakdown in communication among helping services destroys the cooperative climate so necessary for success in this work.

Appropriate referral methods, progress reports, and evaluation are areas which should be shared with and by all team members.

On the one hand, this is the supervisor's administrative task as it relates to the program director and other supervisory personnel, and as it relates to her training responsibility to the homemaker-health aide. Anything short of this will affect the smooth service hoped for, and reduce the effectiveness of the operation of the program.

If one part of a plan calls for a health aide, actively engaged, all other services may be "standing by" for a time. The supervisor of the nursing program would evaluate need for continuation or cessation of that particular focus of service. If the homemaker is active, the homemaker supervisor has the temporary lead role. The caseworker stands by, to use this service as part of the total family plan. She continues to carry her full responsibility as a *caseworker.*

In a cooperative relationship, supervisors share knowledge, work out arrangements for case conferences, are alert to problems, and are willing to take action.

In a cooperative relationship, both supervisors will be active in promoting staff and community acceptance. Each will provide the administration with information needed to evaluate and improve the overall quality of service.

As with any auxiliary service brought to bear on total family living, homemaker-health aide service is carefully designed to meet a particular need. It is a diagnostic tool in multi-problem families. It is a preventive service when used before breakdown has occurred. It is a humane, progressive and practical approach to many of the problems in family life which, unattended, result in family disorganization because of the heavy financial burden of alternative care whether borne individually, or out of public funds.

The supervisor committed to expecting a high standard of professional skill from her staff must support her staff and must direct her part of the services as a member of the coordinated team in a spirit of cooperation, always willing to communicate as she administers, teaches and evaluates her program.

The Teamwork Relationships in Homemaker Service Programs*

by Johnnie U. Williams
Homemaker Specialist, Bureau of Family Services
U.S. Department of Health, Education, and Welfare

Nothing magical happens simply by bringing together a family and a homemaker. Homemaker service encompasses at least four important elements.

The first is *administrative commitment.* This means that the administrator must have deep interest in homemaker service and conviction about the useful purposes it serves. He must take steps to promote community in-

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Excerpt from paper given at 1965 Southwest Regional Conference, American Public Welfare Association, New Orleans, La.

volvement and acceptance of the service. He must plan for continuing financial support of the service. He must secure adequate staff to operate the homemaker service program and to assure that it is coordinated with all agency services. These steps are obviously essential to sound development of the service.

Next comes *administrative activities such as recruitment, selection, training, assignment, and supervision of homemakers.* All of these factors go into the development of a homemaker who, we have a right to expect, will be well-related to the needs of the agency's clients and able to use her skill in child care, household and money management, hygiene and health practices, in human and practical ways to meet the unique needs of the families with whom she works.

The third element is *the social work staff, including caseworkers, who must understand homemaker service, how it may be used in helpful ways and their part in making it effective.* Without such understanding, homemaker service may just as well not exist. Such understanding implies individualizing the family and planning with it and with the homemaker to meet the family's needs. It means finding out that the Jones children don't like to go to school because the other kids laugh at the way they are dressed. It means finding out that Mrs. Jones doesn't know how to buy the best kind and quality of clothing her assistance grant allows, and that the children's clothes look half clean and dingy because Mrs. Jones washes everything once—in the same tub of water! Mrs. Jones needs someone on the scene to teach her about buying and care of clothing. That "someone" is a homemaker.

In the assignment of a homemaker to a family, and from there on, the caseworker helps each to understand the other and to work toward a common goal. The caseworker has continuing responsibility to see that the family has what is needed to facilitate the homemaker's work. It does no good to assign a homemaker to help a mother improve homemaking if there are no cooking utensils, bedding or other household equipment or if the mother is not ready to use the service.

The fourth and last essential concerns the *collaborative, working relationship between the homemaker supervisor and the casework supervisor,* who must help the caseworker-homemaker team to carry out their respective roles. In order to do this, each supervisor must share knowledge with the other. They must work out arrangements for case conferences, be alert to problems which inevitably arise, and they must be able and willing to take the necessary remedial action. Each needs to be active in promoting staff and community acceptance and appropriate use of homemaker service. Each should provide for the agency administrator the information needed to evaluate and to improve the overall quality of the service.

These four essentials that go into homemaker service make one thing clear: it would be a mistake to think of homemaker service as an isolated entity without relation to the vital functions which we carry every day. Homemaker service in public welfare is indeed closely coordinated with other basic social services. It involves a casework plan based on a social study of the needs of an individual or family and careful selection from among agency and community resources—day care, foster homes, nursing homes and other institutions—the service most appropriate to the family's current need.

Homemaker Service: a Diagnostic Tool

Now let us look at some of the situations which require homemaker service to complement casework planning.

> Mrs. Martin, an AFDC (Aid to Families with Dependent Children) mother of three children ranging in age from two to five and a half had been hard hit by the sudden accidental death of her husband the previous year. She had been highly dependent on him for managing their business affairs and for help in caring for the children. Normally a somewhat shy, withdrawn person, she had made almost no friends in the new community to which the family moved when Mr. Martin found a job after several months of unemployment.
>
> The caseworker noticed that, over a period of months following her husband's death, Mrs. Martin gradually became more and more quiet. Often when she visited the home the shades were drawn and the interior of the home unlighted. Mrs. Martin was frequently in bed, complaining of a variety of physical symptoms which were ruled out by subsequent physical examinations. The children, half dressed or still in night clothes, played outside or inside the house with no supervision from Mrs. Martin.
>
> The caseworker was concerned. Was Mrs. Martin physically ill? Was she suffering from a depression? Was she dangerous to herself and/or the children? How could the children be cared for while Mrs. Martin received the attention she needed?
>
> The first step, of course, was to have Mrs. Martin's condition evaluated medically. This meant, at least in the beginning, that Mrs. Martin would have to be away from home on many occasions for several hours at a time. Should a neighbor be requested to baby-sit? Should the children be taken along to the doctor's office? In thinking through what was needed by this family at this particular point in time, the caseworker decided that homemaker service was the best answer. While neighbors frequently respond to and may be used in temporary emergencies, this family required more than could be expected from a neighbor.

A person was needed here who had sympathetic understanding of what the caseworker strongly felt was mental illness. This person would need to care for the children—to bathe, clothe, feed, supervise them and fill their emotional needs which Mrs. Martin seemed unable to do at this time. The home would have to be attended. Equally important, this person would need to be able to work on a day-to-day basis with Mrs. Martin along the lines suggested by the doctor via the caseworker. She would have to share pertinent observations of Mrs. Martin's behavior and attitudes so that a better evaluation could be made of her condition and final plans worked out accordingly. Such a person is a homemaker, trained to work in situations such as this one, clear in understanding her role of supporting the mother and able to relate to her colleague on the agency team—the caseworker.

Here we see the role of homemaker service *diagnosis*, in helping the caseworker to determine more precisely what the problem is and what needs to be done about it. In this case, the children's care and protection are assured by the assignment of a homemaker while the necessary evaluation is made. In addition to caring for the home, the homemaker will, by sharing observations, enable the caseworker and the doctor to determine whether Mrs. Martin is, in fact, mentally ill and what plan for treatment is best in view of her total circumstances.

Homemaker Service: a Preventive Measure

Another case illustrates homemaker service as a *preventive*:

> Feeble and nearly blind, 82-year-old twins, and their "young" 70-year-old brother, all Old Age Assistance recipients, managed quite well in their rural farm home until the latter died of a heart attack. He had done the errands and most of the heavy work around the home. Now these two old people could no longer maintain themselves independently and faced the possibility of nursing home placement.
>
> The caseworker recognized and appreciated their desire to remain in the home which they had inherited from their parents. Having cleared with the doctor that their physical condition was no barrier to their remaining at home, the caseworker suggested homemaker service. The twins were delighted with the homemaker who spent a few hours each day with them. She prepared meals, did light housekeeping and laundry, and brought them news of community activities. Occasionally, she took them with her when she went shopping, but always she sought their suggestions about needed supplies. While caring for them, the homemaker was sharing observations of their mental and physical health with the caseworker.

Again, the information given to the caseworker helped her to know how long these aged persons could remain in their home. Homemaker service is not the best answer in all situations, for all time. There may come a time when aged persons such as these require nursing home care, hospital care or other group living arrangements such as foster family care.

Training and Use of Home Health Aides*

by Ione Carey
Director
Home Health Aide Program
Visiting Nurse Service of New York (N. Y.)

Certain provisions in Medicare recognize that many disabled persons can be cared for effectively at home if appropriate help is available. Appropriate help means the services of nurses, physicians, social workers, or other professional workers, depending on the needs of the patient. But, also necessary in many situations is help for the families of patients.

If we are to maintain our aged at home, prevent or delay hospitalization, and allow for early discharge from nursing homes and hospitals, we must provide not just the services of professional workers for the patient, but services that a family member would perform if a member were available. Even if an aged patient does not live alone, an aged partner, or grown children who are out of the home during the day may not be able to provide these services. Substituting for the family's services is an important part of home health aide service.

While nursing is an essential component of home care services, we know that two out of five persons in our population live in areas where no agency provides nursing care in homes. Also, there is a national shortage of employed nurses.

Two avenues for at least partial answers seem apparent. One is to find more inactive nurses interested in refresher courses and at least part-time work under supervision. The second is to expand the use of auxiliary personnel.

With the increasing number of nursing functions and programs, registered professional nurses have recognized that changes in patterns of staffing are clearly indicated. One of those changes is to delegate to properly trained assistants (licensed practical nurses and aides) those tasks that do not require the preparation and judgment of a registered professional nurse. In visiting nurse services, licensed practical nurses have long been employed.

A more recent development is the employment of home health aides to assist patients and families with much-needed, simple personal care. Home health aides, properly selected, trained, and supervised, can relieve professional nurses of duties that do not require their skills in caring for patients

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at home. In addition, aides can perform those selected but necessary duties that absent or incapacitated family members would do.

Aide's Role Defined

What is a home health aide? What is her relationship to nursing? The aide is an unlicensed, non-professional worker, specifically oriented to the health needs of individuals and families. In our agency, we concentrate on the needs of the chronically ill and aged. An aide works in the home under the guidance and supervision of a registered professional nurse. Her role is a supportive one in nursing, and cannot be a substitute for the service of the nurse. It is the registered professional nurse who is responsible for guiding and supervising the home health aide. It is up to her to see that any therapeutic activity performed is safe for both the aide and the patient.

During the past three years, the Visiting Nurse Service of New York, under a Community Health Facilities Act grant, demonstrated how visiting home aide service to the chronically ill and aged could be provided as an adjunct to nursing service. This service was provided in Queens, one of the three city boroughs serviced by the agency. Now we are extending home health aide service to the other two boroughs.

The pattern we have established is only one way of providing such service. Such factors as needs of the community, availability of personnel, agency policies, and transportation help to determine how aides are trained and used.

Before determining whom to select as home health aides and how to train them, the aides' specific duties must be delineated. This is essential for the aides, the nursing staff, and the public. Administration must identify what is meant by the often-repeated phrase, the aide "assists with personal care and light housekeeping activities." Because home situations differ, the aide's duties must be adjusted to the particular patient and family situation. The typical types of assistance we see home health aides giving are: personal care of patients, meal preparation, routine housekeeping and light laundry.

As instructed by the visiting nurse, the home health aide provides assistance with feeding, bathing, toileting and dressing the patient. She helps the patient maintain range of motion, move from his bed to a chair or a toilet, and walk with canes, crutches, or a walkerette. She promotes the patient's independence in activities of daily living and she may, with a nurse's permission, take the patient outdoors.

Home health aides help plan for nutritious meals, do the shopping, and prepare meals, including specially prescribed diets.

Home health aides make beds, dust and vacuum, wash and dry dishes, and keep the bathroom and kitchen clean. They assist in such routine details of running a home as defrosting a refrigerator or checking the laundry to send out.

Home health aides launder hosiery, undergarments and night clothes. If there is a washing machine in the home or a nearby laundromat, other laundry can be done. They iron for patients, but do not iron heavy items, such as sheets.

Recruitment Described

At the time we were ready to recruit aides in 1963 for our demonstration project, the 42-day newspaper strike in New York City had just begun. We had planned to advertise through the papers. Now, as we look back, we believe that lack of newspaper advertising actually saved us difficulties. We would have been deluged with calls. And yet, in small suburban areas, newspaper advertisements might be helpful. To recruit, we went directly to our staff, the New York City Department of Health, and to the New York State Employment Service. Other sources might be physicians and community agencies. Now, we find that presently employed home health aides are our best source of new recruits.

In recruiting aides some thought should be given to where they live and the problems of travel. Now that we are extending our program, we are not able to hire aides who live in Queens to work in some of the other areas the agency covers. Although they know the program well, travel time would be excessive.

Important in the successful recruitment of home health aides is the establishment of sound personnel policies. At the beginning of our project, we assumed that aides would be employed on a part-time basis, would be paid at an hourly rate, and would have workmen's compensation, disability insurance, and Social Security benefits. We soon learned that most of the women we recruited needed and wanted full-time employment. Lack of a guaranteed salary was a deterrent to recruitment.

Now, personnel policies for our aides parallel those of other employees of the Visiting Nurse Service of New York: an annual salary, paid holidays, vacation and sick time, in addition to the previously mentioned benefits. They continue to have paid pre-employment physical examinations and to share the cost of their annual physical examinations.

Our experience has shown that an aide's previous work experience and the amount of her formal education are not the principal criteria to use in selecting home health aides. We have aides who have completed high school and a few who have only a sixth- or eighth-grade education. Some of our best aides are in each group.

Age may be one factor to consider, but our experience is limited. Most of our aides are between the ages of 40 and 59. An aide in her early 20's may be too inexperienced to cope with the many social and emotional problems that are usually encountered while assisting chronically ill and aged persons. However, we have not worked with sufficient numbers of aides in their early 20's to make a definite statement about this.

First Interview Is Important

In selecting the home health aide, the initial interview is of utmost importance. At this time we try to assess several characteristics: what type of personality does she have, is she outgoing, somewhat shy, or talkative? Can she read, write, and understand English? Does she seem interested in people? What is her background, her previous work experience? What is her personal appearance? Is she prompt?

As we continue to work closely with her, we are better able to judge whether or not she is flexible and tolerant of others; whether or not she has the ability to learn through demonstration and discussion; if she is an accurate, casual observer, and what her reactions are to doing housework.

Although aides are selected as carefully as possible, we know that some will be more successful in one type of situation than another. Who does what best, and for whom, is something we, as employers, need to learn. To assist in the evaluation of aides, we have devised a form which includes the following categories:

1. Personal Qualities
    Personal Appearance
    Punctuality
    Sense of Responsibility
    Initiative and Judgment
    Personality
2. Relationship of Aide to Family and Staff Nurse
3. Opinion of Aide's Ability to Perform Home Nursing and Housekeeping Tasks
4. Remarks and/or Recommendations

The nurse, who works closely with the aide and is responsible for the specific patient, completes this form at specified intervals. Written evaluations of newly employed aides are completed at the end of two weeks, six weeks, three months, and at three-month intervals during the aides' first year; thereafter, twice a year. In addition, each home health aide is continually evaluated as she participates in such activities as on-going educational and team conferences.

Training Is Carefully Planned

Careful thought must be given to the training program for home health aides. While they should not be over-educated, they need sufficient help on a continuous basis to enable them to function efficiently and effectively. From time to time, we have changed our training program, as we gained experience in the use of home health aides.

Our present training program for aides includes orientation conferences and an in-service program. The orientation conferences consist of 20 hours of formal sessions within six to eight weeks of an aide's initial work assignment. We have experimented also with having aides complete these conferences before going into homes. We find that, with the former plan, aides participate more in discussions and find the sessions more meaningful. This, however, may not be feasible in some agencies, due to travel, unavailability of teaching staff, and so forth.

Subjects included in these conferences are: orientation to the agency, given by the director of the aide program; working with people, given by the social work consultant; care of the chronically ill and aged, given by the rehabilitation consultant; home management, given by the nutrition consultant; and introduction to patient care, given by a public health nurse.

The most recent change in this list has been to eliminate the conference with the rehabilitation consultant and to incorporate some of this content into the session on introduction to patient care. We find that it is best to have the nurse demonstrate transfer activities and use of appliances at the individual patient's bedside in cooperation with the rehabilitation or physical therapy consultant. Our mental health consultant will give the class formerly given by the social work consultant, who was a member of the project staff.

The planned in-service training covers three areas. The first includes individual demonstration, supervision and guidance within the home in the area of personal care. Individual conferences are the second area. These are held at the local district office when the aide and the nurse or nurses with whom she works meet to discuss the progress of the patients or aide, or both, and to share information. These conferences add greatly to the aides' morale and strengthen the relationship between the aides and the nurses. Aides are instructed to telephone the nurse or supervisor when needs arise.

Group conferences make up the third area of in-service training. Aides are seen in groups of 15 to 20, approximately every three months. The agenda for these meetings vary, depending on the need. Sometimes they include discussion and evaluation of orientation conferences, revision of aides' report forms and use of case discussions to emphasize and clarify the role of the aide. We will develop this area further as we extend the program throughout the agency.

Eligibility Is Determined

A home health aide is assigned to a patient and family when, in the nurse's judgment, some of the personal care needs of her patient can be met safely by a non-professional worker. The registered professional nurse is still responsible for her patient and makes the decision to place the home health aide as part of her nursing care plan. Criteria for selecting patients should be developed as a guide to the nurse in assessing her patients' needs.

The nurse assesses the need for home health aide service and discusses this with her supervisor before placement of the aide is made.

The conditions under which home health aide service may be provided are: one or more members of the family are aged or chronically ill; the patient and family are willing to have the aide; the patient can be cared for safely at home, if he has some part-time assistance from a home aide (except in unusual situations, the maximum amount of aide service that can be provided in one week is 15 to 20 hours); the patient's physician is willing to have such service for his patient; the patient needs assistance with personal care and housekeeping activities; the primary need, however, is for personal care; no family member is available to give the assistance needed, or the family member who usually gives assistance is ill or incapacitated; and, finally, a responsible person is available to work with the agency (this person can be the patient).

Priorities are given first to patients with potential for rehabilitation. Also given priority are patients living alone all or part of the day, who need assistance with personal care and housekeeping to enable them to remain safely in their homes and thus delay or prevent hospitalization or institutional placement. A third priority consideration is the need for temporary relief for a family with a patient who has a chronic illness.

Evaluation Is Continuous

Every case in which a patient receives home health aide service is carefully re-evaluated by the nurse and her supervisor at least every six weeks.

No time limit is set for the length of service to be given. Nurses stress with both physicians and families that home health aide placement is based on the needs of the patient and availability of personnel. Changes are needed from time to time to provide the best possible care for all patients in their own homes. The present fee for home health aide service is $2.80 per hour. (The average visit lasts 4.5 hours.) The policy regarding payment for aide assistance, like that for the visiting nurse, is based on the patient's ability to pay.

To help the nurse in her assessment of the patient's needs in terms of the criteria just described, we have developed a patient evaluation form. On this form the nurse notes the reasons for aide placement, condition of the patient, personal care to be given and household activities to be performed by the aide, the minimum amount of time needed, comments of the physician and family, and arrangements for payment.

Careful selection and training of aides, criteria for case selection, various tools to aid nurses in assessing patient needs—all are in vain without proper supervision of the home health aides. Supervision is the key to the success of working with home health aides. As nurses we are delegating certain personal care services to aides. Yet, we are legally and morally responsible for the safety of their activities for patients. It follows logically that staff must be prepared for this responsibility.

Plans must be made and time allowed for orienting professional nursing staff on a continuous basis to (1) their role and responsibility for supervision, guidance and evaluation of the aides, and (2) the need for continuous evaluation of each patient's and family's need for aide service. In the Visiting Nurse Service of New York, we have used both individual and group conferences with the field, supervisory and administrative staff to orient professional nurses to this role and responsibility. The willingness of all to share ideas, opinions and problems as they arise has been of great help in the development of the home health aide program.

The employment of home health aides can help provide quality care for patients with long-term illness and, at the same time, make it possible for nurses to use their skills in a broader and more effective way. We must be flexible and willing to experiment with one goal in mind—better care for patients and families who will benefit from this service in their homes.

Section VI

Home Help Services in Other Countries

Homemaker-home health aide services have developed at different rates in various countries, but their role and function appear to be essentially similar in western industrialized nations. This suggests that the emergence of this type of community service is a response of industrial societies to the recognized needs of their members rather than a unique development of an incidental "accommodation type of service" which might be characteristic of one country at a particular time. In other countries, the terms "home help services" and "home helps" are commonly used.

The first paper in this section is an introduction to the scene in several European countries by an English author. The second paper presents a more detailed description of the Swedish pattern of services which is one of the most extensive and intensive programs. Of special interest are the more intensive, residential training arrangements common in many European countries and the variations in the home help services offered.

The last paper sketches the formation and growth of the International Council of Homehelp Services. This has proved to be a stimulating international effort whose experiences promise well for its continuing contribution in promoting effective international communication and collaboration in this field.

World-Wide Trends in Home Help Services*

by Elizabeth Carnegy-Arbuthnott
President
International Council of Home Help Services
London, England

Before one can discuss the development of Home Help or Homemaker Service, as you call it, I think it would be interesting to consider for a moment the changes that have occurred in the family since the beginning of the present century; changes far-reaching and world-wide. Of course, changes are always taking place over the years but the two world wars, even to those countries not directly involved, have accelerated these changes dramatically.

The family at the end of the 19th century was a complete unit and in most cases a large unit, living, working and playing together. Still in rural areas and in less industrialized countries, one can see the pattern. The center of the home, the father and mother, were helped and assisted by the older generation. As time went on, the children developed in the home. There was no need for baby sitters; grandfather and grandmother, unmarried aunts and uncles were there to help. Generally, these families had many children and, as they grew, the elders were adding their helping hands to those of the parents. If one member of the family fell sick, even if it were the mother, willing hands were always available. There were no lonely and miserable old people; they were part of the family and had a job to do. Even the neighbours seemed more neighbourly—possibly because if you lived, worked and played together, you also helped in time of need.

What is the picture one sees today, especially in urban districts? Small families, often not more than mother, father and one or two children. Of course, housing conditions have had a great deal to do with this. There is no room in a small house or flat for the grandparents; they, in their turn, must live alone in other small isolated houses or flats away from the group. Who is one to leave the baby with? Who is going to help when mother is ill? Who is going to look after granny? And the most curious thing, perhaps, is that in spite of living in huge blocks of flats, with literally hundreds of neighbours, one hardly knows the family next door, even to speak to, let alone to call on in an emergency. Here one is talking of the vast majority but, even with the higher income groups, the changing times have made them dependent on help from outside. In the old days, labour was cheap,

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**Paper given at 1964 National Conference on Homemaker Services, Washington, D. C.*

domestics were readily available. Now one gets many demands from people who can well afford to pay, but cannot find help. I well remember a case where a very wealthy old lady, living quite alone, in a large flat, luxuriously furnished, was found starving, half clothed, sitting on a chair where she had been for days, and the flat looked like the worst slum.

Service Varies from Country to Country

Of course, home help service has developed in various ways, according to geographical and local conditions. In countries such as Sweden and Norway, with small populations and vast distances between towns and villages, it is essential that the home help or homemaker is highly trained, as supervision is well nigh impossible, whereas in countries such as ours, small and with a dense population, one needs a great quantity of home helps. In England, in fact, there are 55,000 who need not necessarily be highly trained, as supervision is comparatively easy. Fundamentally, there is a similarity between all services and the types of cases helped are more or less universal, although one does see a divergence in the approach to cases. In some countries, home helps assist all types of cases; in others, such as Holland, the maternity cases are a separate organization in the main scheme. In still others, such as Germany and Sweden, special types of home helps are recruited to assist the aged. Some countries have elaborate training schemes, others hardly any; some train before the home help commences work; others prefer in-service training.

A review of some of the developments in home help service is interesting. First and foremost is the growing care of the aged. The home help service started as a family service to aid the housewife in times of illness, and especially during pregnancy and the birth of the baby. It was an emergency service and, in consequence, limited in time. Still, in some countries such as Norway, Finland and Denmark, two or three weeks is the general allowance and only extended in exceptional circumstances. Then came the question of assisting the aged and infirm. True, countries such as Holland say we have Homes, very good Homes, for the aged. But do old people want to go into Homes? There are those who like a gregarious life, the companionship and safety of a Home, but more and more, the aged want their sticks and stones around them—the familiar things.

As one gets older, one does not want to change, in fact one cannot change. If the 70 to 90-year-olds are to be able to remain in their own homes, they must have help. This problem possibly hit our country rather earlier than any other, as during the war every able pair of hands had to be forced into the war effort. When it was seen by the government that old people were literally dying for want of help, the home help service which, at that time, was exclusively for the family, was expanded to include the aged. Now 75 per cent of all the cases helped in the United Kingdom are the aged and chronic sick and, of course, with such cases help is no longer temporary; in fact, it tends to increase in proportion as the old person gets older.

The development in assistance to the aged is by no means confined to my country. In 1950, the head of the home help service in Sweden came to England to study the care of the aged. Now that country has a well-developed service and the trained home helps can and do help the aged. At times this work is mainly carried out by older women recruited especially for this purpose and given only a short training of three months. As we live longer and, for the reasons I have already given, more and more countries are organizing schemes for the elderly. The United States' concern with the question of the aged is very noticeable throughout this Conference programme.

Another important trend is the modern idea of nursing cases in their own homes, the hospital being only for cases where some kind of emergency treatment is necessary. In one part of France there is actually a team, operating from a hospital, of doctors, nurses and home helps who continue the nursing in the patient's home. It has been found that a sick child responds better under the care of its mother, but the mother will need support if she is given this extra burden. We have all dealt with the rehabilitation of the problem family. With these types of cases, training of home helps is very necessary, but in most cases proves its worth.

Other services that are developing include the care of the mentally sick; the residential home help so important in rural areas; night care; morning and evening service, so valuable where there is no mother and the children are of school age; and, finally, another experiment we are trying in England—day care service or good neighbour service. This service, we are finding, is especially useful for the aged and chronic sick, and could be readily developed to assist the young family. We find old people, living in small flats or rooms, who do not need a trained home help to attend more than once a day, but they do need cups of tea, helping to get up and go to bed, assisting to the toilet, and (in backward countries such as ours!) poking a fire, a few words, a looking in to see they are all right. A neighbour can do this without much trouble or a journey. Possibly she is a young mother with children, who is not working, or a pensioner young enough to just do this job.

Voluntary Service Is Not the Answer

We find, by paying a small retaining fee, many people are willing to help this way. You may well ask, why not a voluntary service—but can one really rely on voluntary services? So many people are enthusiastic at first, but they cool off; they find they have an important engagement; they want a holiday. A small payment makes this work a job like any other, and we find the good neighbours will not leave their cases and, if they have to, will notify the organizer or get a replacement.

The International Council of Home Help Services is growing. There is a saying that there are as many roads as souls, and there are certainly as many variations in home help schemes as there are services. The value of a National Conference such as this is that we have the opportunity of seeing other people's approach to the same problems as our own and, in seeing how they tackle these problems, we learn and can take away many helpful ideas, and this is even more true in the international field. Nationally, we tend to see things from the same angle and it is refreshing, and not a little humbling, to see people doing our job much better than we are doing it ourselves. I have often heard it said by people in the social services, "but surely we are the only people running a home help service." And then, I think of Sweden with its marvelous and well developed organization; indeed, I think of all the continental services and the service here in the States.

The home help service is certainly the social service of the future. It is the backbone of most of the other social services, especially the domiciliary services. As one of our organizers said, "Other social services tend to pass cases on, but when they reach us we have to do something; we must accept our responsibility and go in and support the family, young and old."

Social Home Help Services in Sweden*

by Margareta Nordstrom
Member of Parliament
Adviser to the National Social Welfare Board
Stockholm, Sweden

In Sweden, people who are temporarily unable to cope with their daily housework because of sickness or professional obligations, as well as old people, can obtain assistance for as long as may be needed from the corps of qualified "home helps" employed, supervised and paid by the local authorities in almost every commune in the country. This paper describes the training, duties and conditions of employment of this special category of workers.

Before examining the scheme for social home help in Sweden, I would like to remind my readers that our country has a very small population. We have only 7,500,000 inhabitants. Our biggest city, Stockholm, has a population of 807,000. We live in a country with an extensive territory in relation to the population. The distance from its southern tip to the northernmost border is longer than the distance between Amsterdam and Naples, between Berlin and Barcelona, or between London and Dubrovnik. It is

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sparsely populated and distances are great, especially in the north.

Evidently these circumstances create certain inconveniences for the organization of a service like social home help, compared with conditions in densely populated Central Europe, for instance.

On the other hand, we neither have nor have ever had any slums. We have no problems with conflicting religious communities and we have no race problems.

Service Defined and History Traced

By social home help in Sweden we mean a service organized by a commune or a private body to provide trained manpower, employed especially for this purpose, for families with children, single persons, aged or handicapped people or persons suffering from long illnesses, when they need help with housework and such medical care at home as a good housewife ought to be able to manage. This manpower is employed full time or half time by the commune or private body, and the client pays for the service, if required to do so, directly to the employer and not to the employee.

Training of home helps first began in Sweden in 1920 in a housewifery school in the university city of Uppsala, not far from Stockholm. This school did pioneering work in the field by launching home help services all over the country, under the management of voluntary social, political and religious associations and communal authorities.

The fact that the home help activities in our country began precisely with a training institution was certainly something which strongly contributed to its good reputation. The firm structure of these activities, as well as the experience and wisdom displayed by the management of the school, have been of great value in developing social home help in our country and in the countries which have sent delegations to study our activities. It was, for instance, taken for granted more than 40 years ago that the work of home helps should be distinct from that of nurses and that they should be permanently employed and enjoy vacations, sick pay and certain other social benefits which even today are only being discussed in many other countries.

In 1943 the Swedish Parliament, for the first time, decided to grant government subsidies to communes and, on certain conditions, also to private organizations employing trained home helps. This was originally a proportional subsidy covering about 40 per cent of salary costs; but following the reform of several other forms of government subsidy to communes, it has now been incorporated into a single global subsidy.

The growth in the number of full-time home helps is shown by the following figures: 495 in 1944, 987 in 1945, 1,482 in 1946, 2,613 in 1950, 3,168 in 1955, and about 3,315 in 1961.

Training Provided by State

Full-time home helps have, as a rule, had either 15 months' or three months' training, depending on previous experience and knowledge. The training is, almost without exception, given in boarding schools and it is always full time.

The 15-month courses are given by 14 schools with a capacity of about 225 trainees, and an additional 225 are at present being trained in 15 three-month courses. The capacity of these shorter courses is to be increased by 100 next year, raising the total to 550 trainees.

Training in these schools is free of charge, the costs being borne entirely by the State. In addition, the trainees can obtain scholarships covering all boarding costs in the long courses and two-thirds of the costs in the three-month courses. Widows, divorcees and other single women with dependents can obtain re-training allowances covering all the costs for the course, as well as the support of family members remaining at home, including rent, clothes, home help for the children, etc. This may sound expensive, but it pays in the long run, since it is poor economy to allow a single mother to take a badly paid job when she would be able, after a short course, to enter a comparatively well-paid, highly acceptable occupation.

Those who wish to enter a 15-month course must be at least 19 years of age and have completed at least eight to nine years of basic education. They must also have at least two years' experience in household work and child care and a certificate of personal fitness for the occupation.

The training consists of 10 months in a school, followed by two months of practical experience in a hospital and a home for the aged, and three months in a maternity ward and a children's home. The training period in a hospital and a home for the aged is by no means intended to make the home help into a second-class nurse. We believe that a home help should know as much about medical care as an able housewife. The distinction between her work and that of the district nurse is clearly made.

The curricula of the 15-month courses vary somewhat, but correspond broadly to the following standard curriculum (to which must, of course, be added the five months of practical experience already mentioned):

Theoretical training	*Hours*
Nutrition, diet and cooking	84
Principles of accommodation	63
Technique and organization of housework	32
Materials and sewing	21
Home economy	42
Health and medical care at home	64
Child care	32

Upbringing of children	32
Citizenship and social matters	42
Psychology	32
Singing	42
Swedish language	32
Practical training	
Cooking, baking and preserving	756
Housekeeping and general care of an apartment	168
Laundry	168
Sewing and mending	210
Total	1,820

Great attention is given to good manners and a correct attitude towards work.

Eligible for the three-month courses, which are also full-time boarding school courses, are women with at least five years of well qualified experience in housework and child care. The completion of a five-months' full-time housewifery school course or a five to ten-months' child nursery school course is considered a good merit.

Training in the three-month course is very intensive and includes 526 lessons according to the following curriculum:

Theoretical training	*Hours*
Nutrition and diet	24
Milk hygiene	3
Housekeeping	18
Economy	12
Rationalization of work	6
Health and medical care at home	16
Citizenship and the family	16
Psychology	24
Child care and upbringing	16
Basic knowledge of the occupation	4
General lectures	3
Practical work and demonstrations	
Cooking, baking, preserving, and diet food cooking	90
Sewing and mending	50
Housekeeping	26
Laundry	26
Care of the sick	40
Child care	150
Milking test	2
Total	526

Training is very individual, both in the 15-month and the three-month course. The schools have a number of small kitchens where the trainees learn how to coordinate work, make it more systematic and carry out all housework under varying economic conditions in households of various sizes and with various labour-saving equipment.

The annual rate of resignation from the profession is about 11 per cent, which means that the average home help stays on the job for nine years. Of the 339 home helps who quit in 1961, 68 went to other occupations (mainly nursing), 174 married (some of these may very well return when their children have grown up), 13 quit because of illness, 16 retired on pension and 68 quit for reasons not accounted for.

Forty per cent of our home helps have completed 15-month courses, 53 per cent have completed three-month courses, and seven per cent have acquired equivalent experience through a combination of other forms of training.

Training Should Be Continuous Process

But it should not be thought that home helps are trained once and for all. We live in a changing world with changing problems, and people have changing needs. Basic training must always keep pace with developments, but further training is also necessary. For this purpose, one-week continuation courses are arranged annually for about 300 people in subjects such as social care, psychology, foreign policy and various current topics; they are held in boarding schools in various parts of the country, and meet very important needs. In addition, they provide for home helps, who always work in isolation, an opportunity to see each other.

Indeed, home helps always display an evident interest in social, professional and trade union questions and, in addition to these national courses, many study courses are arranged by local authorities at the request of home helps themselves. In Stockholm in 1961 there were six psychology courses with 15 to 18 participants in each, courses on the care of clothes, and three study circles in the Swedish language with 30 to 35 participants. Home helps also make group visits to communal institutions and administrations, and schools, as well as to vocational rehabilitation centers. More advanced continuation courses will shortly be started in Stockholm, in which 15 particularly able students will be trained as senior home helps.

But just as important as giving home helps a good training and further training is to ensure, by careful selection, that the people who work in the service are suitable. If I were to picture the ideal home help she would be a normal, mature, well adapted and contented human being, with a positive attitude towards the world around her, towards people and their rights and towards the problems of life in general.

Home help is usually granted as an emergency measure to families with children where the housewife is temporarily sick, but it can also be provided for longer periods. We believe it is of the utmost importance to be able to keep the family together during the period of strain which a home is exposed to when the mother is ill, and we are well aware of the importance to the sick housewife of knowing that her family is in good hands.

If the housewife is in the hospital, the home help takes over all the normal duties of the mother, usually spending the whole day in the same home. If the father is also in the hospital (which is by no means unusual following traffic accidents), or works far from home—as a forestry worker, sailor or travelling salesman, for example—or if the housewife is all alone, the home help may have to spend the night in the home as well. This may also be necessary if she lives very far from her place of work.

Social home help was originally entirely an emergency service, but in recent years it has also come to play an important part in preventive and constructive social work.

We have thus begun to provide home help, although so far on an entirely insufficient scale, for mothers taking care of physically or mentally handicapped children, as well as for women caring for chronically sick relatives or aged people in need of constant attention. Even though local councils and communes often pay them a small allowance in remuneration for their work, women with such responsibilities are still burdened with an unreasonable workload and greatly diminished freedom. By providing home help, society can often make life easier for these women.

A new form of assistance introduced in recent years is the provision of home help for families where the mothers are receiving out-patient treatment for mental diseases. Their presence at home during part of the day and during the night often exposes the family, and especially the children, to great strains. In such cases, a home help can do much to maintain the mental balance of the family by taking over the management of the household and, particularly, by paying great attention to the other family members.

Home Help Plays Role of Teacher

An area to which greater attention should also be devoted is assistance for families where the housewife has left the hospital after a long period of hospitalization and must be re-adapted to the family and to household work. Here the home help has to provide the necessary guidance as well as to perform her own duties. She also has a great task to fulfill in families where, because of inability or lack of experience, the mother is unable to cope with the household and leaves it to take care of itself. The guidance and training of such mothers in the running of their homes require great tact and flexibility, and the work done by the home help amounts to preventive child care as well.

If a housewife is sick at home, the home help must, of course, handle the household work and the child care in consultation with her. She must always try not to disrupt family habits and try to create a normal atmosphere of security and confidence.

The work of the home help service has changed in many ways over the past 20 years.

Formerly granted only to the needy, it is now available to all income groups. The daily chores were formerly much heavier in ill-planned apartments with poorly equipped kitchens. Today, almost everyone has a comfortable apartment equipped with central heating, an electric washing machine and a refrigerator (deep freezers are common in many homes, especially among farmers); food habits have been simplified as people switch more and more to pre-prepared or semi-prepared foodstuffs; the ready-made clothing industry has made great advances and the standard of living has risen nearly 100 per cent. In a country of long distances like Sweden, home helps used to spend much of their time getting to and from work, but nowadays public transport has improved, and most families have their own cars and are happy to pick up the home help if she does not have a car of her own.

Swedish Men Are Capable of Managing Household

Swedish men are often both capable of and interested in running the home and taking care of the children, and it is now becoming more and more common for the father to take over the housework as soon as he returns home from work when the mother is sick.

The wider spread of mental diseases and other mental disturbances and stress has, on the other hand, made the work of home helps rather more difficult than before.

In 1961, 14,575 families were aided by home helps because of the confinement of the mother and 50,024 in connection with illness of the mother. In 1,667 cases, home helps replaced housewives on vacation, and 7,448 families received aid for other reasons.

Over 6,000 families could not obtain the help they needed because no home help was available when the request was made. This figure gives no true indication of the inadequacy of the service, as the local authorities do not always keep an accurate record of unsatisfied requests and many families who know, or assume, that no home help is available do not report their need for aid. It is also known for certain that, because of requests from other families, home helps frequently cannot stay in one home as long as would be desirable. With a further expansion of the home help corps, it would no doubt be possible to provide a far more adequate preventive and constructive health and social care service.

With minor variations, most communes give the following instructions to home helps:

1. In her activities, a home help must obey the decisions and instructions of the home help board, given to her by the person whom the board has entrusted with immediate direction and distribution of the work of home helps.

2. When replacing a housewife, the home help must carry out the housewife's daily tasks conscientiously and in an exemplary manner; watch over the welfare of the family with a sense of responsibility and economy; see to it that a sick family member receives the necessary care; and scrupulously follow the instructions given by doctor, district nurse and mid-wife. Insofar as her services concern care of the sick, she is subordinated to the district nurse or other nurse employed by the commune.

3. When a home help finds a home in need of economic or other assistance, she must, in consultation with the home help board, inform the local authority most directly concerned with providing the assistance required — such as the social board, the children's board, the unemployment board, the temperance board, or the health board.

4. Home helps must observe strict professional secrecy concerning families they serve, their members and their state of health, economic situation, etc.

5. A home help may not seek, or accept from the families she aids, any renumeration on her own account.

6. Upon completion of service in a family, home helps are required to make out a service report in an approved form.

We carry out very little inspection of the activities of home helps. After their thorough training we expect them to know their job and treat well the families they serve. The public knows this, too, and if a family is not satisfied we will probably receive a report about it and the responsible social worker will investigate the case. The wide dispersion of the rural population also makes systematic inspection impossible.

Families assisted by the home help service pay a fee in proportion to their income and the number of children. Expenses resulting from death, long illness or other causes, which may temporarily worsen a family's financial situation, are also taken into consideration.

Social home help to families with children is available in 1,020 of the 1,027 communes in Sweden, including all urban centers without exception. The cost of the service amounted, in 1961, to 31.5 million crowns.[*]

Child Care Nurses Are Provided

In 19 communes, and first and foremost in Stockholm, the local authorities responsible for social home help provide child care nurses for working mothers.

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[*] *A crown is worth approximately 20 cents.*

This type of assistance was originally intended to meet the difficult situation of the single mother whose child is sick and cannot be taken care of in a day nursery or at school or in an afternoon home while the mother works. The anxiety of a single mother whose child is sick cannot, of course, be remedied; but if there is somebody to look after the child at home, the mother has a better chance of holding a suitable job in order to support herself and her children. Few employers are, in the long run, indulgent with an employee who, from time to time, is absent from her work in order to take care of a sick child. It is, of course, best for the child, as well as for the mother, if a relative or a neighbour who knows him well can be found to take care of the child even during periods of illness. But few mothers in a big city are so fortunate. Even if the child suffers only from "a simple cold," the day nursery neither can nor should admit him because of the risk of infecting other children. The most commonplace child's illness may thus result in an appreciable economic loss to the mother, even if she has to stay home from her work only for a few days.

Today, the service has been extended to the case of temporarily sick children in families where both parents are working, thus rendering valuable assistance to professional people such as doctors, teachers, social workers or nurses, who find it extremely difficult to leave their work.

In 1962, 198 child care nurses looked after 4,432 cases in Stockholm alone. These nurses are often former home helps or child nurses, or housewives of the "grandmother" type. Their initial training consists of a 72-hour course or a three-day information course, depending on their previous experience, and every third week they attend meetings at which lectures are given on how to keep sick children occupied, and on children's diets and children's diseases.

The demand for child care nurses for sick children fluctuates widely, with peak periods in the spring and autumn, when infectious diseases are most common. It is thus not possible to hire full-time personnel in sufficient numbers, since they could not be given full employment all the year round.

Child care nurses are paid at the rate of 4.50 crowns per hour. The charge for the service may be any proportion of this rate, or it may be provided free of charge, depending on income.

Special Help Designed for the Aged

Because apartments are small in Sweden, and because of the migration of large groups of our population in connection with industrialization and the increased employment of married women, people cannot take care of their aged relatives to the same extent as they used to. On the other hand, old people do not wish to go into an institution unless they are absolutely helpless, nor do they want to be dependent on their relatives; indeed, all old people in Sweden now have their old-age pensions to support them, and the new, cheap, modern flats that are continually being built for the aged and handicapped make it unnecessary for anyone to enter an institution for economic reasons. But, the fact remains that many of the old people who want, at all costs, to preserve their independence and to stay in their own homes are entirely or partially incapable of looking after themselves.

Since 1950 we have been providing a special home help service for such old people along the lines of a similar English service. This has been an outstanding success. It differs from ordinary home help in that it consists of permanent rather than emergency assistance at certain hours of the day or on certain days of the week, depending on each case, and is provided by middle-aged housewives working part time. These women are often called home Samaritans, after the "Good Samaritan" of the parable.

Unfortunately, home help for the aged was sometimes presented in its early days as a kind of universal help which could and should replace all other forms of help. It was therefore asked, and by no means without reason, whether it would hinder improvement of the standard of homes for the aged, to which much interest was devoted at that time, and the expansion of institutional long-term care for the sick. People also wondered whether it would be possible to meet the demand for manpower under full employment conditions, especially in the countryside, and whether the initial enthusiasm would last when the service began to require more formal organization.

However, most communes and county councils (the latter are responsible for caring for the sick in Sweden) continued their efforts to create adequate institutional care, as far as economic and personnel resources permitted. As for the manpower problem, 60 per cent of the communes have reported that they have no difficulties in recruiting home Samaritans; 30 per cent encounter periodical difficulties, especially in finding recruits of a satisfactory standard.

According to a government investigation on this special service, on February 1, 1954, help was being provided for about 5,000 aged people; during the last week of January 1956, 12,008 persons were helped by 5,177 home Samaritans. During the whole year of 1954, help was provided for 18,325 old people; the corresponding figures for 1956, 1959 and 1961 were 32,211, 50,493 and 59,991.

Home help for the aged is now available in 730 of the 1,027 communes in Sweden. In 615 of them, the service is provided by the local authorities, in 102 by Red Cross committees (often subsidized by the communes) and in 13 by other principals.

The organization of the service at the level of the commune is a matter of capital importance for the success of the scheme. The home Samaritan organizer has to be capable not only of allotting the work and supervising it, but of understanding old people and their needs and knowing the strengths and weaknesses of each of her staff. She should be capable, after visiting an old person, of judging whether home help is in fact the most suitable form of assistance; if so, she has to decide which home Samaritan to assign to the particular job; and she must find time to follow each case personally, to give the Samaritans their instructions and to change assignments if necessary. She must also be capable of evaluating the number of hours of service required in each case. Some old people who would be better off in an institution or hospital remain at home, either because of a shortage of institutional accommodation or because they flatly refuse to finish their days in an old people's home; such cases demand round-the-clock service. Others, on the contrary, are perfectly fit to attend to most of their own needs and require only a few hours' help a week. Hence, the automatic allocation of time, without precise evaluation of the needs of each case, can lead to heavy and wasteful expenditure.

In communes where the service is efficiently run, the organizer therefore plays essentially the same part as the matron of an old people's home. She watches over the health of her charges and calls in a doctor or nurse or arranges for them to be moved into an institution or hospital if the need arises. She can also encourage them to take an interest in things and engage in suitable pursuits and activities, such as those available in the clubs and study circles organized in many communes.

Experience has shown that a home Samaritan organizer should not have to handle more than 150 cases. The best training for an organizer is that of a matron of an old people's home or a nurse with experience with old people —requiring a three-and-a-half-year course in each case.

Home Samaritan Service Proves Useful

The home Samaritan service has become firmly established in a number of communes over the last few years, which gives cause for satisfaction in view of the economic and social interests at stake. The total cost of the service to all communes in 1961 was 33.2 million crowns. The old people pay a fee in proportion to their means, no charge being made if their only source of income is an old-age pension. By way of example in Stockholm, where old people with no private income draw a minimum annual pension of 3,850 crowns and live rent free, four out of five cases received the home Samaritan service without charge.

In addition to this, 24,189 old persons and invalids received aid from trained home helps in 1961, about 17,000 of them in cases of acute illness, at an estimated cost to the communes of about 6.6 million crowns.

The training of home Samaritans is now mostly arranged in cooperation between the State and the Red Cross, often under communal sponsorship. The courses average 132 hours in length, and cover care of the sick, social legislation, diet, laundry, how to run a home and how to organize work. The home Samaritans are not expected to possess the same degree of flexibility and versatility as a trained home help. On the other hand, regular visits by somebody they can talk to may be just as important to an old person as having his daily chores taken care of. This "somebody" may be their only contact with the outside world; thus the home Samaritan must know how to gain confidence by an attitude of helpfulness, tact and discretion; she must treat the aged with friendly politeness, one might even say, old-world courtesy.

Food Is Problem for the Aging

Another aspect of the service deserves mention. An investigation made by the State Institute for Public Health has clearly shown that many old people living alone eat the wrong sort of food. Experience with home help activities over the years has taught us that bad diet does not always result from poverty; it may well be the result of ignorance of the importance of balanced nutrition or of increasing passivity. Old people often simply cannot muster the courage to go out on treacherous roads to buy food in bad weather and to carry it home and then cook their small portion. If the home Samaritan is aware of her important task in this connection, she may well be able to introduce old people to a better and more varied diet. Many doctors assert that the state of health of old people is often noticeably improved after they have received home help.

We have now had 12 years of experience with home help for the aged, during which period the service has proved of such value that in the future it will surely not be considered as a passing fancy or an emergency measure caused by shortage of institutional accommodation, but as a clear expression of our growing responsibility for the individual and respect for individual freedom.

This being said, however, it should be stressed that it has always been customary in Sweden for relatives, friends and neighbours to help each other in cases of sickness and old age. It would be wrong, out of eagerness to plan and organize, to suppress the healthy and spontaneous help among relatives and neighbours which still exists to such a large extent both in our cities and in the countryside.

In Sweden the county councils are directly responsible for the care of the sick, in cases of both acute and chronic illness.

In cases of prolonged sickness, home care by teams of doctors, district nurses and home Samaritans is well developed in most counties. Unfortunately, no precise figures covering these activities are available. Their scope is indicated, however, by the fact that at least 10 million crowns have been allocated for the salaries of Samaritans handling long-term cases. These activities are organized in the same way as home help for the aged, with the difference that the district nurse is always the organizer and co-operates closely with the nursing homes dealing with cases of chronic illness.

Wages and Conditions of Employment Discussed

Trained home helps are regularly employed by the communes at a monthly salary fixed on the basis of negotiations between the Association of Swedish Cities and the Association of Swedish Country Communes on the one hand, and the Union of Municipal Civil Servants on the other. The initial salary in places with the lowest cost-of-living index is at present 918 crowns per month, with a final salary, after nine years' service, of 1,069 crowns. The initial salary in places where the cost-of-living index is highest is 1,031 crowns, with a final salary of 1,202 crowns per month. Home helps are entitled to paid vacations of up to 28 days. Upon reaching 60 years of age, they receive a pension amounting to 60 per cent of their annual salary.

Home Samaritans trained in the short course of 132 hours, or having a thorough experience with household work, are at present paid 4.50 to 5 crowns per hour. Their wage rate is also fixed by negotiation, in this case between the Association of Swedish Cities and the Association of Swedish Country Communes, and the Union of Municipal Workers. As a rule, home Samaritans work part time.

At the age of 67, home Samaritans retire on pension, on the same conditions as all other Swedish citizens. They are entitled by law to paid vacations in proportion to their working hours per month.

Both home helps and home Samaritans receive cash compensation during sickness, regardless of whether or not they have contracted the illness during the course of their work, and receive free hospital care.

The working hours of home helps amount to 180 in four weeks. They are obliged to adjust themselves to the timetable of each home, but are granted compensatory free time for overtime, and are entitled to at least five full days off in each four-week period. If they spend the night in the home where they are working, they receive 5 crowns extra for the inconvenience.

Neither home helps nor home Samaritans are permitted to accept tips or gifts, but the former may accept free meals in the home if they are offered.

Conclusion

In the provision of home help services, Sweden undoubtedly ranks among the foremost nations. But we shall not be able to say that the home help service is fulfilling its great task in society until each family with children, in need of temporary help because of the illness of the housewife, or for other medical or social reasons, can be guaranteed the assistance of a capable home help regardless of income, number of children or place of residence. Nor can we rest content until the home help service has been granted its proper place in constructive health and social work, and until all citizens, including chronically sick persons who want to stay at home, are helped with the daily chores they cannot manage to do and with the simpler forms of care for the sick.

A well-known American social welfare worker once remarked about social work in general: "We know far better than we do." By this he wanted to point out that good ideas must be translated into action, possibilities into reality and intentions into accomplishments.

In spite of our successes, we have reason to say of the home help service that we know how it should work and that we must now concentrate our efforts on converting our intentions into reality even more efficiently than hitherto.

Purpose, Function and Work of International Council of Homehelp Services*

by Carmen Jonas
Director
Home Helps of the
German Association of Public and Private Care
Frankfort, Germany

In October 1965, I was invited to Oxford by the English Institute of Homehelp Organizers, and it seems to me simply miraculous that the International Council of Homehelp Services, together with the National Council for Homemaker Services, could organize a study group in order to comment on the topic of a congress arranged by the International Conference of Social Work. For at that Homehelp Conference at Oxford, which took place only 10 years ago, it was stated that the founding of an International Homehelp Organization was completely out of the question, the differences among the various countries, as well as their viewpoints regarding this service, being insurmountable. When, in those days, someone dared to consider the homehelp as a kind of "social profession," the reaction of many people was deepest distrust, just as if we intended to disqualify the profession of the social worker!

**Paper given at the International Conference of Social Work in Washington, D. C., September 1, 1966.*

In 1959, however, only two and a half years later, we founded the International Council on Homehelp Services—surely a sign that there is always room for a hearty optimism—even in this present world. Or, maybe, it is the fact that we colleagues of the Homehelp Service are particularly well prepared for overcoming difficulties which seem at first insurmountable. Through our daily work we are so used to them, but we never cease to believe, and usually even with success, that a miracle will happen: be it that the homehelp we need now so badly will be available by miracle, or be it that the financing which was denied to us in the first place, miraculously, will yet be granted. Since its founding, the International Council of Homehelp Services has organized three international congresses, thus offering with its topics, as well as with the contents of its reports, a complete picture of the entire homehelp work and, considering the limited time, I believe hardly any other branch in social work can show similar records.

Homehelps' Position in Total System Analyzed

In Woudschoten, Holland, in 1959, the position of homehelp within the system of social helps was explained and discussed as the topic of our congress.

In 1962, in Paris, the work of the homehelp in relation to the family in its present, changed state was analyzed. And it was concluded that the usefulness of the homehelp in assisting in social work is mainly based on the fact that the homehelp works vicariously for the mother and housewife in the intimate sphere of the family. In many ways she can act as the "longer arm" of the social worker or the doctor. For her task, she never needs to apply any modern method of social work.

All she does is in the nature of personal assistance. But this personal assistance is not only particularly practical, it is also very welcome to the families and, finally, can be afforded at relatively low costs. This applies to all countries where we have set up our homehelp services. In actual fact, there is nothing to be surprised about, for the problems a homehelp faces are, according to Dr. Ellen Winston, "the universal problems of the whole human race."

The third International Homehelp Congress in Koenigstein, Germany, was subsequently carried through under the heading: "Homehelp, a Modern Social Profession." Here a convincing picture was drawn of the homehelp service as a part of social services in general. Margareta Nordstrom (Sweden) actually expressed the results of the Congress at Koenigstein in two sentences:

The first one reads: "The better we train our homehelps, the wider the scope of tasks we can put them in charge of, yet, they will always remain what they are—namely, homehelps." (This, by the way, is the reason the training of the homehelp, also on an international level, is playing such a vital role.)

And the second sentence: "The greater the efficiency of the organizer, the better the chances of our homehelp service becoming an integral part of social work and family services."

Here again it becomes evident why there is a strong tendency—also on an international basis—towards putting social workers in charge of directing homehelp organizations. But, unfortunately, there are too few social workers everywhere.

Obviously, the subject "Competent Direction" will continue to occupy the International Council of Homehelp Services in the future. From my own experience, I should like to mention at this point what we undertook in my organization, based on suggestions received at Koenigstein. This year, in May, we arranged an international seminar on the "Organizer," together with representatives from Belgium, France, Holland and Switzerland, the results of which proved extremely interesting for all of us. The evaluation has not yet been completed. We are working on a summary in the usual form of a synopsis.

International Council Conducts Study

In spite of the fact that the International Council of Homehelp Services has existed only a few years, it has not restricted itself to the preparation and execution of its congresses, but has also carried out a considerable amount of scientific work.

In 1958, a questionnaire was drawn up and sent to all countries in order to establish the actual differences among the homehelp services of the various countries. On the basis of responses received, it was possible to formulate the regulations for the future international organization and establish the International Council of Homehelp Services. This was followed by a second questionnaire in 1960, addressed to the various organizations which, in the meantime, had become members of our Council. This time, the questions were more specific about such things as the number of homehelps, training and grants.

As a result of answers to both questionnaires, after a working period of four years, a booklet was published called "Homehelp." First and foremost, it gives a description of the international meaning of the word "Homehelp" —i.e., an account of all the various kinds of work a homehelp does. Secondly, it contains the Regulations and By-Laws of the International Council of Homehelp Services which also provide answers regarding the purpose of the International Homehelp Organization.

According to the Regulations, the International Council of Homehelp Services will try to:

1. further cordial relations between the organizations of homehelp services in the different countries,
2. study questions related to homehelp work,

3. exchange ideas on problems concerning homehelp work,
4. organize congresses, conferences or meetings,
5. collect information from different countries, promote research and distribute the results,
6. create possibilities for reciprocal visits among the members of the organizations of homehelp services in the different countries.

Finally, the booklet "Homehelp" contains a list of all members. It does not follow that in each case only the relevant *country* would hold membership in the International Council of Homehelp Services. Germany, for instance, is represented by five members, Switzerland by three and France by 14.

The membership list also gives information on addresses of national committees, if any, addresses of members, number of homehelps and other data interesting for work on an international level.

The booklet "Homehelp" was received from the printers just in time for the Congress at Koenigstein and appeared in three languages: English, French and German.

The Congress at Koenigstein fully confirmed the contents of the booklet "Homehelp," and clearly indicated trends of the future:

1. Cooperation with other social and health services, which in most countries is just beginning, will be opening up the most fascinating aspects for our future homehelp work.

2. Training and refresher courses for the homehelps are essential. Here it was quite evident what progress has been made during the past years. There were no doubts as to the necessity of training. Even plans for minimum training started to become a subject of discussion. In preparation of the excellent report of Mathilde Daschinger, Director of the School for Home Helps in Zurich, Switzerland, the International Council of Homehelp Services carried out another scientific research: a comparison of the training of homehelps from six different countries, with a view to finding a training scheme to be applied and appreciated on an international level by all countries. Mathilde Daschinger used this synopsis as a basis for her significant report to which we shall refer often in our future homehelp work.

3. The strict demands brought forward for the homehelp regarding the legal aspects of her employment and insurance were also of great importance. These were based on the knowledge expected from her and the great responsibility placed on her shoulders.

4. Finally, the manifold duties of the organizer were commented on, together with the relevant qualifications, training and refresher courses.

5. It should also be mentioned that during the discussions of the study groups one question repeatedly emerged which is also attracting our attention in discussions of the Executive Committee of the International Council—that is the nomenclature on an international level.

In this particular instance, may I remind you that on the occasion of the International Conference of Social Work in Athens, the social workers of the whole world were asked to assist in clarifying the definitions in social work on an international level.

To illustrate that this is not unimportant for the term "Homehelp," too, let me state one single example—the terminology used in various countries:

in the U.S.A.	Homemaker
in Great Britain	Homehelp
in Belgium	Aide Familiale
in France	Travaileuse Familiale
in Switzerland	Aide Familiale and Hauspflegerin
in Germany	Hauspflegerin Familienpflegerin u. Dorfhelferin
in Austria	Familienhelferin

This is only a small selection. In addition, at Koenigstein a regulation for the future was suggested which is already in use in Holland, Switzerland and Germany, whereby the homehelp who was graduated from a homehelp school and received her recognition as a homehelp differs not only in the amount she is paid, but also in her designation, from the helper who received only initial instruction in homehelp. In Germany, we call the latter a "homehelp assistant." As you see, another addition to the difficulties of international nomenclature!

Having drawn for you a picture of the work of the International Council of Homehelp Services, I think you will see that it does not restrict itself merely to preparing for the following congress.

But this would be illusionary if only for the reason that the participants themselves had taken over the initiative by giving special orders to the International Council via the demands laid down by the study groups. The studies to be undertaken and reported on at the next congress are part of the findings and recommendations of the study groups on which Dr. Pense (Manager of the German Association for Public and Private Welfare) reported at Koenigstein. Apart from all the reports we heard at Koenigstein, these recommendations are the reason I am convinced that the results of the Koenigstein Congress will serve us a guide for our work during the next 10 years.

The study groups presented to the International Council the following objectives:

1. to establish the necessary training for the homehelp if she is to meet the manifold requirements,
2. to formulate a professional image of the homehelp as well as to com-

pare the legal regulations of her employment on an international level,
3. to compare the training and refresher courses of organizers,
4. to clarify the international nomenclature with regard to homehelp,
5. to prepare the forthcoming international congress for homehelp.

The Executive Committee, newly elected at Koenigstein, immediately began work toward these objectives by taking the following action:

- a committee from Switzerland, Holland and Germany is working on the question of the training of the homehelp;
- the professional image of the homehelp is being worked out by France and Belgium;
- the training and refresher courses of organizers are being dealt with by England, Holland and Switzerland;
- the clarification of the nomenclature is considered a matter of all three committees within the framework of their special duties;
- representatives of these countries which already have held a congress will put their experience at the disposal of those preparing for the next International Homehelp Congress.

The next International Homehelp Congress will take place in May 1969, in Brussels. I hope we shall be able to meet again in Europe and that until then our work will continue to develop in the same satisfactory, progressive fashion it has during the past years. You may rest assured that anything the International Council of Homehelp Services can do to reach our goal will be done.

APPENDIX A

HOMEMAKER-HOME HEALTH AIDE SERVICE

Selected References

ADMINISTRATION, ORGANIZATION AND FINANCING

Brodsky, Rose. "Administrative Aspects of 24-hour Homemaker Service," CHILD WELFARE, Vol. 45, No. 1 (January 1966), p. 34.

This article, which describes a program under the auspices of a voluntary agency but whose services are purchased from a public agency, gives straightforward advice about many aspects of administering an around-the-clock program.

Division of Chronic Illness Control, New Jersey State Department of Health and Visiting Homemaker Association of New Jersey. STATISTICS AND COSTS FOR VISITING HOMEMAKER SERVICES IN NEW JERSEY. Trenton: New Jersey State Department of Health, 1963. 28 pp. (Available from the Department on request)

This is a manual for reporting basic statistics and costs and for compiling and reporting statistical information on the service. Sample forms are interspersed with the text.

North Carolina State Department of Public Welfare. HOMEMAKER SERVICE IN PUBLIC WELFARE—THE NORTH CAROLINA EXPERIENCE. Washington, D.C.: U. S. Department of Health, Education and Welfare, 1965. 48 pp. (Single copies available from the Department, Washington, D.C. 20201)

This pamphlet contains suggested guides implicitly stated for the development of a state-wide program under the administration of county departments of welfare and supervision of the state agency. Administrative criteria for staffing, duties and responsibilities of the aide, some guides for training aides on the job, scheduling, and placement are all included.

BIBLIOGRAPHIES

Colorado State Department of Public Welfare. "Homemaker Service—A Bridge to the Future," THE LIBRARY COUNSELOR, Vol. 21, No. 2 (April 1966). 34 pp. (Available on library loan from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019. Purchase from the Department, Denver, Col., 80203. $1)

This is an annotated bibliography, listing reference material on the subject under headings such as "background and general information," "meeting special needs—children, aged and chronically ill," "recruitment, selection and training of homemakers."

Edwards, Mabel I. SELECTED REFERENCES ON HOME CARE FOR CHRONICALLY ILL AND AGED—AN ANNOTATED BIBLIOGRAPHY. Iowa City, Iowa: Institute of Gerontology, University of Iowa, 1967. (Available on library loan from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019. Purchase from the Institute of Gerontology)

This document is in four sections: Coordinated Home Care, Homemaker-Home Health Aide Service, Meals on Wheels, and Dental Home Care Services. Each section contains general information regarding major sources of information on its subject.

Morlock, Maud. HOMEMAKER SERVICES—HISTORY AND BIBLIOGRAPHY, Children's Bureau Publication No. 410. U.S. Department of Health, Education and Welfare, Welfare Administration, Children's Bureau, Washington, D.C.: U.S. Government Printing Office, 1964. 116 pp. (Available from Superintendent of Documents, Washington, D.C. 20402. 40 cents)

This annotated bibliography contains historical materials listing the extant published material relating to homemaker services in all the fields concerned with these services.

CONFERENCE REPORTS AND PROCEEDINGS

1959 National Conference on Homemaker Services, February 10-11, 1959, Chicago, Ill.

HOMEMAKER SERVICES—REPORT OF THE 1959 CONFERENCE, Public Health Service Publication No. 746. Division of Public Health Methods, Public Health Service, U.S. Department of Health, Education and Welfare. Washington, D.C.: U.S. Government Printing Office, 1960. 257 pp. (Available from the Superintendent of Documents, Washington, D.C. 20402. $1.25. Also available in libraries and state public health and welfare departments)

Stimulated by a request for a conference from the National Committee on Homemaker Service, the Children's Bureau took the initiative in drawing together 26 national voluntary organizations and 8 units of the U.S. Department of Health, Education, and Welfare to sponsor the conference jointly. The proceedings include five major papers given at the conference in Part II, while Part I has chapters covering the deliberations on topics such as financing, planning and recommendations.

1960 Annual Meeting, National Committee on Homemaker Service, October 13-14, 1960, New York, N. Y.

PROCEEDINGS—ANNUAL MEETING, NATIONAL COMMITTEE ON HOMEMAKER SERVICE, National Committee on Homemaker Service. New York: The Committee, 1960. 51 pp. (Mimeographed) (Available on library loan basis from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019)

Four of the papers presented at this conference are included in this document, each of the authors having contributed to the development and expansion of the service. Summaries of the eight workshops are also included.

1962 International Congress on Home Help Services, September 1962, Paris, France.

PROCEEDINGS OF THE INTERNATIONAL CONGRESS ON HOME HELP SERVICES, 1962. English translation, Welfare Administration, U.S. Department of Health, Education, and Welfare. Washington, D.C.: U.S. Government Printing Office, 1962. 71 pp. (Available from the Superintendent of Documents, Washington, D.C. 20402. 30 cents. Also available from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019)

This document contains five major papers given at the Congress, and brief resumés of "Home Help" organizations from 11 European countries, Canada and Japan. Delegates and members of the planning committee are listed.

1964 National Conference on Homemaker Services, held April 29-May 1, 1964, in Washington, D.C.

REPORT OF THE 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES, written by Virginia Doscher. New York: National Council for Homemaker Services, 1964. 76 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1)

The 80 papers presented at the conference are synthesized in this report under topical headings such as administration, training, financing, and personnel policies. The conference was a joint effort between the Council and units of the U.S. Department of Health, Education and Welfare, voluntary organizations and the American Medical Association.

1965 International Congress on Home Help Services, September 1965. Koenigstein, Germany.

PROCEEDINGS OF THE INTERNATIONAL CONGRESS ON HOME HELP SERVICES, 1965. English translation, Welfare Administration, U.S. Department of Health, Education and Welfare. Washington, D.C.: U.S. Government Printing Office, 1965. 102 pp. (Available from the Superintendent of Documents, Washington, D.C. 20402. 35 cents. Also available from the National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019)

Theme of this congress was "Home Help—A Modern Social Profession." The report contains summaries of the work groups, and nine major papers presented at the congress.

1966 International Conference of Social Work, September 1966, Washington, D.C.

URBAN-DEVELOPMENT, ITS IMPLICATIONS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES. A session was held on September 8, 1966 for delegates to the international conference who were interested in this specialized service. No proceedings were planned for publication, but two of the papers given at this one-day meeting appeared in the HOMEMAKER-HOME HEALTH AIDE BULLETIN, published by the American Medical Association in cooperation with the National Council for Homemaker Services.
"Training for Homemaker Services," by Clara Ottesen of Norway, appeared in Vol. 8, No. 5 (September 1967).

"Purpose, Function and Work of the International Council of Homehelp Services," by Carmen Jonas of Germany, was published in Vol. 9, No. 1 (January 1968).

"The Contribution of Homemaker Service Toward Meeting Needs of People in an Urbanized Society," by Dr. Ellen Winston of the U.S.A., is planned for publication in Vol. 10, 1969.

1967 Annual Meeting and Forum, National Council for Homemaker Services, May 4-5, 1967, New York, N. Y.

REPORT OF 1967 FORUM ON HOMEMAKER-HOME HEALTH AIDE SERVICE, written by Evelyn Hart. New York: National Council for Homemaker Services, 1967. 32 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.50)

"Current Realities and Future Opportunities for Homemaker-Home Health Aide Service" was the theme of the first annual forum held by the Council. The published report is a condensation of the various papers and workshop discussions.

HIGHLIGHTS, 1967 ANNUAL MEETING AND FORUM OF THE NATIONAL COUNCIL FOR HOMEMAKER SERVICES. New York: The Council, 1967. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. 50 cents, handling costs)

These are mimeographed copies of the twelve papers presented at the forum.

1968 Annual Meeting and Forum, National Council for Homemaker Services, held April 24-26, New York, N. Y.

REPORT OF 1968 FORUM ON HOMEMAKER-HOME HEALTH AIDE SERVICE, written by Patricia W. Soyka. New York: National Council for Homemaker Services, 1968. 62 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1.50)

DESCRIPTIONS OF HOMEMAKER-HOME HEALTH AIDE PROGRAMS

Brodsky, Rose; Kuralt, Wallace; and Oettinger, Katherine. HOMEMAKER HOME HEALTH SERVICES FOR FAMILIES WITH A MENTALLY RETARDED MEMBER. New York: National Council for Homemaker Services, 1966. 36 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1)

Three papers, presented at the 93rd Annual Forum of the National Conference on Social Welfare held in Chicago May 29-June 3, 1966, were published by the Council as descriptive of extended and expanded services to meet special needs of children and families.

Brodsky, Rose. "Philosophy and Practices in Homemaker Service," CHILD WELFARE, Vol. 37, No. 7 (July 1958), pp. 10-14.

The author emphasizes that homemaker service "cannot stand alone as a housekeeping service" but, instead, is a social service.

Burford, Elizabeth, and others. NEW APPROACHES TO HOMEMAKER SERVICE. New York: Child Welfare League of America, 1964, 20 pp. 65 cents. (Available from the League, 44 East 23 St., New York, N. Y. 10010)

This pamphlet includes reprints of four articles (all program descriptions), which appeared in the journal, CHILD WELFARE, during 1962 and 1963.

Burns, Mary E. and Goodman, Julia Ann. "The Teaching Homemaker in a School Project," CHILDREN, Vol. 14, No. 5 (September-October 1967), pp. 171-174.

This article describes a special project financed by the Office of Education to assist students in using educational opportunities effectively, and to help socially maladjusted pupils frequently identified as drop outs. The use of homemakers as teachers of parents and pupils in their own homes is attempted and its success evaluated.

Children's Bureau. HOMEMAKER SERVICE: HOW IT HELPS CHILDREN, Children's Bureau, U.S. Department of Health, Education and Welfare, Washington, D.C. U.S. Government Printing Office, 1967, 24 pp. Children's Bureau Publication No. 443-1967. (For sale by the Superintendent of Documents, Washington, D.C. 20402. 35 cents)

Although an interpretive pamphlet, this document contains comprehensive descriptions of a variety of programs in which homemaker services are helpful to families and children.

Doodson, Norman. "Services for the Aged in Britain," CANADIAN WELFARE, Vol. 40, No. 1 (January-February 1964), pp. 23-28.

This article describes the "home help" service which developed rapidly in Great Britain as the National Health Act was implemented.

"Earlham Care Program: A Small Town Organizes Basic Services for its Aging," AGING, No. 109 (November 1963), pp. 1-6.

A program in Iowa, initiated in 1963, is described in which the major features are homemaker service, handyman service, activity centers, counseling service, transportation within the community, and meals-on-wheels.

Epstein, Laura. "Casework Process in Crisis Abatement," CHILD WELFARE, Vol. 44, No. 10 (December 1965), pp. 551.

The author describes the use of the homemaker in a treatment plan when mothers are hospitalized for psychiatric therapy, emphasizing the advantages of early decision to use the service.

Foresman, Louise and Stringer, Elizabeth. "Homemaker Service in Neglect and Abuse, Part I. Strengthening Family Life; Part II, A Tool for Case Evaluation," CHILDREN, Vol. 12, No. 1 (January-February 1965), pp. 23-26.

Describing the use of homemakers in helping families reported as neglecting and abusing children, the role of the homemaker as observer and teacher is shown as vital in the preventive and protective service of a public and a voluntary agency.

Goldfarb, Dora and Manko, Phyllis. "Homemaker Service in a Medical Setting," CHILDREN, Vol. 4, No. 6 (November-December 1957), pp. 213-218.

How a family agency and a hospital cooperate to give homemaker service to families is related.

Hall, Madelyn N. "Home Health Aide Services are Here to Stay," NURSING OUTLOOK, Vol. 14, No. 6 (June 1966), p. 44.

Describes a community nursing service in Philadelphia where aides have been used as auxiliary personnel. Qualifications, job duties, priorities of assignments and something of the costs of the services are included in the content of the article.

Hart, Evelyn. HOMEMAKER SERVICES FOR FAMILIES AND INDIVIDUALS. Public Affairs Pamphlet No. 371. New York: Public Affairs Pamphlets, 1965. 21 pp. (Available from Public Affairs Pamphlets, 381 Park Ave. S., New York, N. Y. 10016. 25 cents)

Written in popular style, this pamphlet describes various patterns of service and presents a great deal of general information.

Hicks, Florence J. "Training Neighborhood Health Aides," AMERICAN JOURNAL OF NURSING, Vol. 65, No. 4 (April 1965), p. 79.

This article describes the use of indigenous neighborhood aides in working with hard-to-reach families in Washington, D.C. Recruited to work under the direction of health personnel the aides were charged with the responsibility of helping families to make full use of health facilities as both a preventive and treatment service.

Hill, Esther M. "Helping Low-Income Parents—Through Homemaking Consultants," CHILDREN, Vol. 10, No. 4 (July-August 1963), pp. 132-136.

In this article the service described is under the auspices of a public school district and the homemakers are employed by the school board. A part of the adult education program, these homemakers perform a teaching role, guiding parents in creating a better home life for their families.

Hughes, Georgia P. "Homemaker Service for Migrants," PUBLIC WELFARE NEWS, Vol. 27 (December 1963). Published by the North Carolina State Board of Public Welfare, Raleigh, N. C.

This paper describes the work of a county welfare department which employs homemakers to work with crews of farm workers who come to harvest crops, bringing their families with them.

Humphrey, Jackson C. "Homemaker Service in a Psychiatric Care Program," REPORT ON CONFERENCES ON AGING AND LONG-TERM CARE. Chicago: The American Medical Association, 1965, 105 pp. (Available from the AMA, 535 North Dearborn, Chicago, Ill. 60610, upon request)

This article describes the experience at Evansville, Ind. State Hospital for Mentally Ill which began as a project in 1960. The homemaker service is housed with the hospital's Social Service Department. Although a small service in numbers (36 families received service) the structure, training, and coordination with other hospital personnel suggests a model for practice.

Johnson, Nora Phillips. "Homemaker Service for Children with Psychiatric Disorders," CHILD WELFARE, Vol. 40, No. 9 (November 1961), pp. 18-22, 29.

The author suggests that homemaker service can make a unique contribution to the treatment of emotional disturbances by placing a helping person in the child's actual living situation.

Kadushin, Alfred, "Homemaker Service," CHILD WELFARE SERVICES, New York: The MacMillan Company, 1967. 625 pp. (Chapter 7, pp. 275-299)

This chapter is comprehensive and descriptive of a variety of ways in which homemaker service is used, primarily in serving families with children. It includes history, administrative aspects, case illustrations and a bibliography.

Leedahl, Norma. "A Homemaker Speaks . . ." Paper given at 1967 North Dakota Conference of Social Welfare held in Bismarck, N. D., September 25, 1967.

This brief paper is a personal statement and testimony by a homemaker in a public welfare agency. The author describes the team relationship with the agency caseworkers and tells of some of her working experiences as a homemaker.

Preston, Nathalie D. "Home Economists Have Much To Contribute To Homemaker Service Programs," JOURNAL OF HOME ECONOMICS, Vol. 57, No. 2 (February 1965), pp. 103-106.

Stressing the point that there is no age or physical status or economic level to which homemaker-home health aide service is limited, this article describes the way in which home economists participate in these programs.

Public Health Service, Division of Public Health Methods. HOMEMAKER SERVICES IN THE UNITED STATES, 1958: TWELVE STATEMENTS DESCRIBING DIFFERENT TYPES OF HOMEMAKER SERVICE. Washington, D.C.: U.S. Government Printing Office, 1959. 99 pp. (Out of print but available, upon request, from U.S. Department of Health, Education and Welfare, Public Health Service, Washington, D.C., 20201)

This is a compilation of reports of homemaker service programs in 12 cities prepared for use at the 1959 National Conference on Homemaker Services. Major variations in administrative patterns, as well as policies and practices, are shown.

Restad, Wesley. "A Homemaker Program to Strengthen Family Life," PUBLIC WELFARE, Vol. 21, No. 3 (July 1963), p. 125.

This article describes a program in rural Minnesota under the auspices of a county public welfare department, with close cooperation of the county public health department.

Rice, Elizabeth P. HOMEMAKER SERVICE IN MATERNAL AND CHILD HEALTH PROGRAMS, Washington, D.C.: U.S. Children's Bureau, 1965. Processed material, 12 pp. (Available, on request, from the Bureau, Washington, D.C. 20201)

The article contains criteria for establishing a priority service for mothers and children with special needs.

Safier, Ruth. "Homemakers for Chronically Ill and Aged: A Description," THE GERONTOLOGIST, Vol. 6, No. 3 (September 1966), pp. 150-153.

While this article describes the project of the St. Louis Health and Welfare Council it also points to several principles—that of careful selection of staff, orientation, training, and supervision which stimulates growth and allows the homemaker freedom to function as a helper, using her own judgment within the framework of the agency. Case examples show the initiative and sensitivity of the homemakers.

Shames, Miriam. "Use of Homemaker Service in Families that Neglect Their Children," SOCIAL WORK, Vol. 9, No. 1 (January 1964), pp. 12-18.

An experimental project carried on in the Los Angeles County Bureau of Public Assistance, financed by the U.S. Children's Bureau, is described. Homemakers were assigned to 12 families, with a total of 67 children, known to have been receiving public assistance for many years and to have serious problems of neglect and deprivation. The report suggests that starting families in the direction of rehabilitation is one of the most challenging tasks of a homemaker service.

Stringer, Elizabeth A. "Homemaker Service to the Single-Parent Family," SOCIAL CASEWORK, Vol. 48, No. 2 (February 1967), pp. 75-79. This article describes an organized homemaker service program in New York which gives high priority to serving children who otherwise would require placement in foster care, including children of unmarried mothers.

Trager, Brahna. "The Use of Homemaker Service in Preserving Family Life," Unpublished paper presented at Minnesota Welfare Association Annual Conference, St. Paul, Minn., March 16, 1965. (Mimeographed)

Preventing hasty placement of children at times of family crisis, maintaining stability when mothers are hospitalized or are otherwise absent, and assisting mothers who know little about child care and household management are described as equally valid uses of homemaker-home health aide staff members.

Williams, Johnnie U. "The Caseworker-Homemaker Team," PUBLIC WELFARE, Vol. 23, No. 4 (October 1965), p. 275. (Reprints available from Social and Rehabilitation Service, U.S. Department of Health, Education and Welfare, Washington, D.C. 20201)

Emphasis in this article is placed on the team relationships for diagnosis and treatment, and in raising the levels of living of families disorganized by multiple problems and poverty.

Winston, Ellen. "Current Realities and Future Opportunities for Homemaker-Home Health Aide Services." Paper given at Annual Meeting and Forum of the National Council for Homemaker Services, May 4, 1967, in New York City. (Available from National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019)

The author stresses the nature of this specialized service as a "family service" which includes the single adult living alone. She describes the use of homemakers in situations where children are neglected and even abused and the levels of living are inadequate for healthy, normal family life.

Wolff, Myrtle P. "Surmounting the Hurdles to Homemaker Services," CHILDREN, Vol. 6, No. 1 (January-February 1959), pp. 17-22.

Eight years of experimentation and programming for homemaker services to families with children in both urban and rural areas of North Carolina proved to the State Department of Public Welfare that this service has special values in preserving family life. Some of the results are described in this article.

Yaguda, Mrs. Asher. "Homemaker-Home Health Aide—A Unified Service," HIGHLIGHTS—1967 ANNUAL MEETING AND FORUM. New York: National Council for Homemaker Services, 1967. (Available from the Council, 1740 Broadway, New York, N. Y. 10019, 50 cents)

Terminology used in the 1965 Amendments to the Social Security Act, with regard to medical care and payment of treatment for eligible patients in their own homes, caused confusion in the planning for, and use of, "health aides" and "homemaking aides." The author emphasizes that the aides have the same training and perform the same functions under the professional supervision of sometimes a public health nurse and sometimes a social worker.

Zeis, Evelyn H. "Recruitment and Selection of Homemakers." Paper given at 1964 National Conference on Homemaker Services, Washington, D.C., April 30, 1964.

A description of effective techniques used by one agency to recruit, screen and select homemakers.

HOME CARE PROGRAMS

The following references are listed regarding home care programs since there is considerable use made of homemaker-home health aides in such programs. Also, because of the similarity of the terms used there is often confusion that a "home care" program is the same as "homemaker services," or that it encompasses the homemaker-home health aide service. Frequently a coordinated or comprehensive home care program employs its own homemaker-home health aide staff but, also, such programs may purchase the homemaker-home health aide service from the agency operating such a service in a given community.

Browning, Francis E. "Organizational Patterns for Coordinated Home Care Programs," HOMEMAKER-HOME HEALTH AIDE SERVICE IN HOME CARE PROGRAMS. New York: National Council for Homemaker Services, Inc., 1967, 43 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1)

One of a group of papers presented at 94th Annual Forum of the National Conference on Social Welfare in Dallas, Tex., May 21-26, 1967, in a session co-sponsored by the American Medical Association, American Hospital Association, and National Council for Homemaker Services. This paper points out the lag in the development of this needed service as being due to confusion and profusion of terminology and auspices, failure to identify the program with patient needs, and lack of money and qualified health-services personnel.

Grant, Murray. "Health Aides Add New Dimension to Home-Care Programs," in HOSPITALS, Vol. 40, December 1, 1966, pp. 63-67.

The article describes the function of the home health aide, how aides are recruited, trained, and utilized. The strategic role they play in contributing to the success of the home care program is underscored.

Lester, Eileen E. "Home Care Programs Meet Community Need," HOMEMAKER-HOME HEALTH AIDE SERVICE IN HOME CARE PROGRAMS. New York: National Council for Homemaker Services, Inc. 1967. 43 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1)

This article identifies the contribution of social workers and homemaker-home health aides in coordinated home care programs usually operated under medical auspices. It also gives some statistical data regarding the expansion of home care programs since 1965 legislation.

Public Health Service, Division of Medical Care Administration. THE PHYSICIAN AND HOME CARE—CASE STUDIES AND COMMENTARY. Washington, D.C.: U.S. Department of Health, Education and Welfare. 1967. (Available from the Department, Washington, D.C. 20201)

This is a kit composed of seven pamphlets and reprints of two articles, including a 1966 AMA Staff Task Force report on Home Care. It contains guides for developing and administering coordinated home care programs.

Smith, Lucille M., and others. LET'S UNDERSTAND HOME CARE. Chicago: American Public Welfare Association, 1964. 33 pp. (Out of print, but available in libraries of schools and public health and welfare agency libraries; also available on loan from library of National Council for Homemaker Services, 1740 Broadway, New York, N. Y. 10019)

Four papers presented at conferences on public welfare programs and problems, sponsored by the Association, make up the content of this booklet. The basic element of a home care program is that it is a physician-directed program, whether hospital-based, agency-based, or community-based. Early discharge of patients from hospitals, and treatment for patients to prevent hospitalization are viewed as the goal of the home care program team. The role of the homemaker-home health aide as a member of the treatment team is described in two of the papers.

Winston, Ellen. "Health-Welfare Partnership in Programs for Low Income Groups," in AMERICAN JOURNAL OF PUBLIC HEALTH, Vol. 57, No. 7 (July 1967) pp. 1100-1106.

The article includes factual data re: low incomes among segments of the population, and outlines the five specific services which Title XIX of the 1965 Social Security Amendments will provide by July 1, 1967 through certified agencies and institutions. A plea is made for a true partnership relationship between health and welfare personnel and institutions.

Winston, Ellen. NEW OPPORTUNITIES FOR MEDICAL SERVICES. Washington, D.C.: U.S. Department of Health, Education and Welfare. (Available upon request from the Department, Washington, D.C. 20201)

This pamphlet has factual data regarding the number of states which had implemented Title XIX programs by 1966. It describes the range and scope of the program as intended by the Congress. The benefits to different client groups such as children under 21 years of age found to be "medically needy" and the "medically indigent" are explained. Some tasks of the homemaker-home health aide are described.

STANDARDS AND PRINCIPLES

CWLA STANDARDS FOR HOMEMAKER SERVICE FOR CHILDREN, Committee on Standards for Homemaker Service. New York: Child Welfare League of America 1959. 45 pp. (Available from the League, 44 East 23 St., New York, N. Y. 10010. $1.25)

This document is coded numerically for quick reference use so that sub-headings can be located in relation to chapter headings which are: homemaker service as a child welfare service, the role and development of the homemaker, the caseworker in homemaker service, organization and administration of the service, and community planning for homemaker service. The pamphlet includes a selected reading reference list and is indexed.

GUIDELINES FOR THE DEVELOPMENT AND UTILIZATION OF HOME HEALTH SERVICES IN THE COMMUNITY. Committee on Practice and Executive Committee, Division on Community Health Nursing Practice, American Nurses Association. New York: the Association, 1967. 34 pp. (Available from the Association, 10 Columbus Circle, New York, N. Y. 10019. $1)

The focus of this booklet is that of the public health nurse and personnel who may be employed to assist and to be supportive of public health nursing service.

STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, Committee on Standards. New York: National Council for Homemaker Services, 1965. 45 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1)

This document was developed by a committee representative nationally of health and welfare agencies providing homemaker-home health aide services, and governmental units of the U.S. Department of Health, Education and Welfare. Under the auspices of the National Council for Homemaker Services, this first edition of the standards is being widely used.

ADDENDA TO STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, Committee on Addenda. New York: National Council for Homemaker Services, 1969. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. $1)

These Addenda resulted from the Committee's review and up-dating of STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES.

TRAINING OF THE HOMEMAKER-HOME HEALTH AIDE

HOMEMAKER-HOME HEALTH AIDES—TRAINING MANUAL. Prepared by the National Council for Homemaker Services under the auspices of the Office of Education, U.S. Department of Health, Education and Welfare. New York: The Council, 1967. 181 pp. (Available from the Council, 1740 Broadway, New York, N. Y. 10019. Members, $3; non-members, $5)

This document is the training guide developed and recommended by the national organization for this specialized field of service. A practical how-to-do-it manual, it contains 10 units of instruction with teaching resources and suggested learning experiences geared to the educational objectives of each unit.

Lefson, Eleanor E. "One Week's Training for the Home Health Aide," NURSING OUTLOOK, Vol. 14, No. 6 (June 1966), pp. 48-50.

This article is written from the viewpoint of a public health nurse. Aides are trained in certain technical skills in nutrition and "rehabilitation therapy." The author points out the necessity for training and the expectations held for the aides who will contribute as team members to the care of the chronically ill and others cared for in their own homes.

Trager, Brahna. TRAINING HOMEMAKER-HOME HEALTH AIDES FOR COMMUNITY SERVICE. Washington, D.C.: General Service Administration, 1967. 142 pp.

This training guide was developed under the auspices of the Office of Economic Opportunity, Community Action Program and the U.S. Department of Health, Education and Welfare, Public Health Service. It is intended for the use of teachers in health and welfare agencies developing training programs for homemaker-home health aides. It includes a sample training outline and a selected reading list.

TEACHING METHODOLOGY

Corsini, R. J., and Howard, D. D., (Editors). CRITICAL INCIDENTS IN TEACHING. Englewood Cliffs, N. J.: Prentice Hall, Inc., 1964. 222 pp.

This book is a compilation of critical incidents used as illustrative materials for teaching in professional schools. It is designed to assist teachers in developing techniques for stimulating problem-solving discussions.

Oswald, Ida. AN ANNOTATED BIBLIOGRAPHY ON AUDIO-VISUAL INSTRUCTION IN PROFESSIONAL EDUCATION. New York: Council on Social Work Education, 1966. 61 pp.

References are grouped in three sections on social work literature, literature from related professional fields, and general references. This document was produced to stimulate the interest of professional schools' teaching staffs in the use of audio-visual aids.

Swell, Lila. "Learning Theory and the Use of Role Playing in Casework Teaching," JOURNAL OF EDUCATION FOR SOCIAL WORK, Vol. 4, No. 1. (Spring of 1968)

The author, an associate professor in a graduate school of social work, describes some classroom experiences with role playing and the conscious use of learning theory in developing role-playing opportunities for students.

Appendix B

Homemaker-Home Health Aide Service in the United States

Report of 1966 Survey
by Grace W. Bell
April 1968

This report of the 1966 survey of homemaker-home health aide service in the United States consists of two parts. The first section contains the analysis of the findings. The second consists of 13 tables containing the most important tabulations of the data from the survey. Additional data are reported in the analysis.

Joint Survey by National Council for Homemaker Services and Former Bureau of Family Services, Welfare Administration, U.S. Department of Health, Education, and Welfare.

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Homemaker-Home Health Aide Service in the U.S. — 1966 Survey Report

Introduction

The field of homemaker service has been growing so rapidly in the past few years that it has been difficult to keep abreast of the number of agencies and homemakers, let alone current practices, in the field. This is a report of the first effort to study in detail, nationwide, some of the program characteristics and agency practices in homemaker-home health aide services. Previous surveys have been more limited in scope, gathering basic statistical data and information primarily for directory purposes. This survey had a two-fold purpose: to up-date the directory of homemaker-home health aide service agencies,[1] and to secure comprehensive data about the kinds of programs and operational practices involved in providing homemaker service.

The month of October 1966 was chosen as the survey month to correspond with the previous surveys. The data relate only to programs actually in operation during that month. They reveal growth of programs, suggest some emerging trends with respect to auspices and groups served, and indicate some areas needing further development. They point up the great lacks in service in respect to coverage of persons, geographic coverage, and comprehensiveness of service provided, and in agency policies and practices in respect to personnel, salaries and wages, employee benefits, and collection and utilization of program data.

Although homemaker service was initiated in the United States more than half a century ago, growth in the first 50 years was extremely slow and uneven. A national conference was held in 1959, sponsored by some 32 national voluntary organizations and Federal governmental units. This conference grew out of the efforts of the National Committee on Homemaker Services which had sponsored earlier conferences. It gave a great spur to the development and extension of service and led to the creation of the National Council for Homemaker Services. One of the first activities of the National Council was to sponsor a national conference on homemaker services in Washington, D. C., in 1964, with the cooperation of the Welfare Administration of the U.S. Department of Health, Education and Welfare.[2] At that time, a new directory of homemaker services was published by the Public Health

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[1] *DIRECTORY OF HOMEMAKER-HOME AIDE SERVICES, 1966-67, National Council for Homemaker Services, 1967.*

[2] *REPORT OF THE 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES, National Council for Homemaker Services, 1965.*

Service, with the assistance of the Children's Bureau and the Bureau of Family Services in the U.S. Department of Health, Education and Welfare.

Because of the accelerated growth of homemaker service following the 1964 conference, the National Council soon determined that a new directory was urgently needed. It sought the collaboration of the Welfare Administration and its Bureau of Family Services for this purpose (since reorganized as a part of the Social and Rehabilitation Service). Because of the need for data about the kinds of current programs and practices in the field, it was decided to make this a comprehensive survey of homemaker-home health aide service, public and voluntary, throughout the country. This is a report of the findings of that survey.

Methodology

The survey followed the pattern previously employed in developing directories of homemaker service agencies. Joseph O. Wilson was employed as project director by the Bureau of Family Services to conduct the survey. A small advisory committee worked with him to develop the plan and content of the survey. Members were: Mrs. Betty H. Andersen of the National Council; Mrs. Ione Carey, Visiting Nurse Service, New York City; Eileen Lester, U.S. Public Health Service; Mrs. Gladys Lawson, Children's Bureau, and Mrs. Grace W. Bell, Bureau of Family Services, Chairman. Mrs. Gertrude Morton of the Bureau of Family Services provided technical consultation in the development of the survey design and the questionnaire.

The Community Profile Data Center, Bureau of Health Services, tabulated the statistical findings. Royal Crystal and his staff developed the detailed tables contained in this report. Thus, this project involved the active collaboration of the National Council for Homemaker Services, the former Welfare Administration (now a part of the Social and Rehabilitation Service), U.S. Department of Health, Education and Welfare, and the Public Health Service, U.S. Department of Health, Education and Welfare.

In an effort to assure the inclusion of all active operating homemaker-home health aide programs, the project undertook to locate every known agency in the United States and Canada. Letters were sent to all agencies which had been included in the 1963 directory to enlist their assistance in identifying new agencies. The U.S. Public Health Service circularized state health departments, and the Bureau of Family Services and the Children's Bureau circularized all of the state public welfare departments. In addition, the help of the Family Service Association of America, the Child Welfare League of America and the United Community Funds and Councils of America was enlisted. Notices of the project were carried in NEWS, published by the National Council for Homemaker Services, and in the HOMEMAKER-HOME HEALTH AIDE BULLETIN, publication of the American Medical Association. In spite of these efforts, however, several new agencies came to light after the October deadline. These were included in the directory, although some were unable to give the detailed program data called for by the survey.

The content for the questionnaire was developed by the advisory committee with the assistance of a number of knowledgeable people in both the social welfare and health fields. The questionnaire was tested in four homemaker-home health aide agencies, although it was not possible to do a complete field test. The questionnaire proved to be generally usable and most agencies had very little difficulty with the majority of the questions.

A total of 1,232 questionnaires were mailed in September 1966; 902 responses were received, 853 from the United States, 49 from Canada. Of the U. S. agencies, 680[3] gave the requested data and are included in this report. A number of agencies responded that they were not actually operating a service program but were either purchasing service or securing it from other agencies which provided homemaker-home health aide service. Those not in operation until after October 1966 were included in the directory but are not represented in the findings. Likewise, data obtained from the Canadian agencies are not included in this report, although the agencies were listed in the directory.

Throughout this report, the generic term "homemaker" is used to mean also "home health aide," "family aide" or any other term by which this worker may be known. Likewise, "homemaker service agency" is used generically to designate the agency employing the "homemaker," regardless of the official name of the particular agency. The National Council recognizes the basic principle of a unified service, regardless of the variation in terminology currently in use.[4] Moreover, responding agencies indicated no uniformity in practice in respect to type of agency—e.g., some visiting nurse associations and health agencies use the term "homemaker" not "home health aide." The trend would appear to be toward recognition and acceptance of the Council's position in respect to "homemaker-home health aide service" as one service, not two different services, although this is by no means universally accepted throughout the field.

Finally, in using this report, one needs to keep in mind the fact that Puerto Rico provided data for two statewide programs, one in public welfare and one in public health, while in actual practice there were 79 local welfare programs in operation. Thus, the total number of local public welfare programs is 357 rather than 279 as shown in the tables. It was not possible to develop the tabulations to reflect this fact nor would the resulting data

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[3] *Actually 758, since Puerto Rico reported all of its 79 local public welfare programs as one statewide program.*

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[4] *STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, National Council for Homemaker Services, 1965.*

have been comparable to the 1963 data since Puerto Rico reported all of its local public welfare programs as one at that time also.

Growth

Probably the most significant finding of the survey was the growth of the service. This was reflected in the number of agencies, the number of homemakers employed, the people served, and geographic coverage. (See Tables 1 and 6.)[5] The actual number of agencies more than doubled between October 1963 and October 1966. The number of homemakers employed and the number of families and adults served also doubled during this period.

Geographic coverage had improved markedly. Only two states reported no formally organized program; three states—New Jersey, Puerto Rico and Rhode Island—reported some service available statewide. Other states were well on their way to statewide coverage—particularly North Carolina, New York, Minnesota and Wisconsin. However, there remained great areas in which there was no program of any kind. Homemaker service agencies tended to be concentrated in areas serving a population of 50,000 or more, although 97 reported serving an area in which the total population was under 25,000. Another 102 agencies operated in communities of 25,000 to 50,000 population.

Although there were more agencies in the larger population centers, the quantity of service available to the population was no greater.

Voluntary agencies were likely to be located in the larger communities. Public agencies in the larger communities tended to serve the total geographical area in which they were located. Among the 97 agencies operating in communities with less than 25,000 population, 60 were public welfare, and 20 were public health programs. Moreover, among the 102 agencies serving populations of 25,000 to 50,000, 60 were public welfare and 21 were public health programs.

The pattern of growth has been greatest in the public programs, reflecting the increased commitment on the part of public welfare and public health to homemaker service, in both sponsorship and financial support. Programs under public welfare auspices more than tripled from 1963 to the 279 reported in this study. Those under public health increased from 15 to 78. Growth in the voluntary field was over 65 per cent to 309, under a variety of auspices, but with family or children's agencies the most important (Table 1).

The number of homemakers employed increased more than 100 per cent, from 3,908 in 1963 to 7,965 in 1966 (Table 6). However, a few agencies did not report these data so that the actual number employed is under-reported.

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[5] *1961 and 1963 Data from DIRECTORY OF HOMEMAKER SERVICES, Public Health Service, U. S. Department of Health, Education, and Welfare, Publication No. 928: 1964.*

Of the total homemakers employed, the proportion of part-time employees increased from 35 per cent in 1963 to 45 per cent in 1966. Social welfare agencies tended to employ a greater percentage of homemakers on a full-time basis, whereas the health field relied more heavily on part-time homemakers. Public welfare employed more than five full-time homemakers for each part-time one. Public health agencies employed more than two part-time for each full-time homemaker. Family and children's agencies relied more heavily on full-time homemakers than did other types of voluntary agencies, employing almost two full-time to each part-time homemaker. In contrast, independent agencies employed almost three part-time for each full-time homemaker, accounting for more than one-half of the total increase in part-time homemakers since 1963.

The number of homemakers employed (Table 6) should be examined in conjunction with the number of persons served (Table 1) and the hours of service (Table 3), for a clearer picture of the total service provided.

While the growth is heartening, it is obvious that the service is only in the beginning stages. There is both inadequate geographic coverage and inadequate quantity of services available where agencies are presently located.

Recipients of Homemaker Service

The survey sought data about the who, what and why of homemaker service. For families with children, for adults, for both? What service? For what purpose?

Most agencies, 413 of the total, served both families and adults, although the *proportion* serving both decreased slightly from 65 per cent in 1963 to 61 per cent in 1966. The proportion of agencies serving only families with children increased slightly and the proportion serving only adults decreased slightly.[6]

Relatively few agencies limited service on the basis of sectarian background; 199 reported limiting service to low-income groups; three reported limiting the service to those who could pay fees for service; 222 reported that they provided service only for their own clientele. More than half of all public welfare agencies limited service to low-income groups; very few voluntary agencies limited service to this group. The majority of agencies which reported that they discontinued homemaker service (although it may continue to be needed) when other kinds of help from the agency were no longer needed were public agencies—78 public welfare and 26 public health. Only 34 voluntary agencies, 19 of which were visiting nurse associations, reported that they did so.

Various other limitations in respect to groups served were reported by

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[6] *See DIRECTORY OF HOMEMAKER SERVICES, 1963.*

44 voluntary and 69 public agencies. Although the data are incomplete, it would appear that the great majority of agencies provided homemaker service as a major service in itself, not requiring that clients be receiving other social or health services from them in order to be eligible for homemaker service. This is not to imply, however, that homemaker services were provided by the homemaker alone, without professional assessment of the need, determination of the appropriateness and effective use of homemaker services, and termination of the service when appropriate.

Most agencies serving families with children provided service where there were ill or disabled parents and/or children, although not necessarily including personal care. Most provided service for mothers and children in the pre-natal and post-natal periods. Most reported assisting parents who were overburdened because of the care of others. Assistance to parents lacking knowledge of home management and child care in order to raise the level of living was also reported by most agencies, as was assistance to families with a mentally ill member. Service in respect to neglect and abuse of children was reported by the majority of the respondents. About two-thirds reported helping in situations where there were disturbed children and adolescents and in relieving stress in foster families.

Of the 466 agencies serving adults (Table 2), 425 reported helping the frail aged who needed assistance in the home; 394 provided personal care to the frail aged; 400 provided personal care for the ill and disabled; more than half served the mentally ill and the mentally retarded adult.

Nearly all of the agencies serving either or both families with children and families with adults (643) had as a basic purpose the preservation of the home and family life. The few which did not report this as a purpose were mostly health agencies. Similarly, most indicated that their objectives included raising the level of living of the family, providing supportive services and substitute care for children and/or adults. About 70 per cent reported assisting professional staff in diagnosing the situation and developing an overall service plan as an objective of homemaker service.

Most agencies operate continuing programs, but more than one in seven (100) reported that they were operating as a time-limited project; 63 of these projects were in public agencies (40 public welfare, 14 public health, nine other), and 37 were under voluntary auspices (17 family and children's agencies, six visiting nurse associations, four home health care programs, seven independent homemaker agencies, three other). These figures suggest the need for the field, as well as the particular project agency, to be alert to ways of assuring the continuation of the program after the project period, if services are to continue to be available to people helped by the projects.

Many agencies reported that they tried to meet the need for more than a "9-to-5" service. Sixty-two public and 38 voluntary agencies reported that they provided service as needed for the groups they served, without restrictions as to emergency or temporary needs. Of these, 55 were public welfare agencies, 15 family and children's agencies, and 16 independent agencies. Five public health, three visiting nurse associations and four home care agencies reported similar 8-to-24-hour service. Service on Saturdays and Sundays was reported by 361 agencies, while nearly 400 reported that they provided early morning and/or early evening service (6-8 a.m. and 5-9 p.m.).

Professional Direction and Supervision

Next to financing homemaker service, questions relating to practice in respect to direction and supervision are probably raised most frequently. The survey sought information on the overall direction of the service, the day-to-day supervision of the homemaker, the use of consultants to augment knowledge and skill in providing service, as well as the educational background of the directors. While the data reported were incomplete because some respondents found the questions confusing, interesting information regarding current practice was revealed.

Among agencies which responded to questions relating to the professional direction of the homemaker service, social work was reported as the major field of preparation by the largest single group—355. Nurses were next in number, with a total of 163, followed by 127 home economists. A variety of other educational backgrounds was reported, including public school education, business, psychology and economics. More than a third of the directors were reported as having a graduate degree, the largest number in social work with a few in public health nursing, public health education, etc. Those with graduate training were equally divided between public and voluntary agencies. The level of education reported for 288 directors was the baccalaureate degree; 44 directors had no more than a high school education, 23 of whom were in voluntary and 21 in public agencies (Table 4).

While social agencies tend to employ social workers as directors of homemaker service and health agencies turn to nurses for program direction, the data showed that this is not always so (Table 4). Nineteen of the public health agencies, 11 of the visiting nurse associations, and eight of the 23 home health care agencies employed directors with social work training. Thirty independent agencies reported directors with social work training and 19 directors with nursing background. On the other hand, 17 social agencies reported nurses as directors of the service. Directors with training in home economics were reported by 46 public welfare agencies, 15 public health agencies, 29 family and children's agencies, 13 VNA's and 12 independent agencies.

Many of the smaller agencies, employing fewer than five homemakers, reported that the director gave only part time to duties as director of the homemaker service program while also carrying other agency responsibilities. Most of the agencies which employed a number of homemakers also employed full-time directors.

Day-to-day supervision of the homemaker was provided in a variety of ways. Some agencies reported that the homemaker received this help from the caseworker or nurse assigned to the particular case, having no continuity of supervision from one case to another unless she happens to be so assigned. Other agencies reported that overall supervision, for administrative purposes only, was provided by the director of the service, while supervision as it related to the particular case was provided by the caseworker in the social agency or the nurse in the health agency. A number of agencies reported that the director of the service provided both administrative and day-to-day professional supervision of the homemaker. Agencies employing large numbers of homemakers usually employed several supervisors and assigned a quota of homemakers to each.

Of the 680 agencies, 672 reported that they provided some continuing supervision for their homemakers. However, 248 agencies reported no regularly scheduled conferences with their homemakers. All but nine provided for supervisory conferences for crises or emergencies. Thus, responses indicated that the practice in the field is not uniform and that many agencies are not now meeting the standards for supervision set by the National Council for Homemaker Services.

What is the proper ratio of homemakers to supervisors? Not all agencies reported the number of homemakers and/or the number of supervisors employed (Table 6). If full and part-time staff are lumped together for a very rough picture, the proportion of supervisors to homemakers *averaged* by type of agency about as follows:

Public health agencies	1 to 4
Public welfare	1 to 5.5
Voluntary health agencies	1 to 8
Voluntary family and children's agencies	1 to 9
Independent community agencies	1 to 15

The survey also undertook to examine practice in the use of consultants to augment professional content of homemaker service. The majority of agencies reported using one or more consultants as shown:

Consultants	*Agencies*
Social worker	599
Physician — medical	596
Nurse	558
Psychiatrist	415
Home economist	326
Nutritionist	300

Physical therapist	276
Occupational therapist	142
Other (includes psychologists, speech and other therapists)	136

Generally, social agencies reported more frequent use of consultation from medical specialists than health agencies reported use of social work consultation. One-third of the public health and one-fifth of the voluntary health programs reporting did not use social work consultation from any source.

Four hundred and sixty-three homemaker service programs reported consultation from other units of their own agencies; 565 reported arrangements for such help without cost from other community agencies; 188 reported securing paid consultation for homemaker service.

Training

The survey sought information about the nature and extent of training provided homemakers. Initial training was provided for newly employed homemakers by 537 of the 680 agencies reporting. Most of them provided training prior to assignment to a case. Some agencies included sessions both prior to and after assignment to cases. The length of the initial training period varied greatly, with about 45 per cent of the voluntary agencies and 32 per cent of the public agencies reporting fewer than 21 hours. On the other hand, 16 per cent of the public agencies and eight per cent of the voluntary agencies reported 80 or more hours of intial training (Table 7).

Some 88 public welfare agencies reported no organized initial training program. These were largely child welfare agencies which employed only one or two homemakers on an "as needed basis," part-time. It would appear that these agencies relied upon day-to-day supervision by the caseworker to provide such training. The majority reported that they planned and carried out their own training activities, although 106 reported contracting with another agency or organization to provide training, usually a vocational training institution, university extension service, or similar institution. Another 103 agencies secured training through other resources such as Office of Economic Opportunity and Manpower Development Training programs.

Apparently, more agencies provide initial training than continuing in-service training. While more than 500 agencies reported having organized training programs, only 88 reported weekly in-service training sessions and only 160 reported monthly sessions. While the tabulated data on the content of training were not entirely clear, examination of individual responses indicated that many agencies which served families did not provide training in family relationships, common human needs, child behavior, etc. Moreover, not all agencies which provided personal care reported that they provide training in this area. This was true alike for health and welfare, public and voluntary, agencies. It is remarkable that so many agencies reported no training of their homemakers in respect to purpose and function of the agency and the role of the homemaker. Was the failure to report such training due to the fact that they overlooked these essential aspects or did they not consider this "training"? Generally, public agencies were more likely than voluntary agencies to report this as part of their training program.

The picture was equally uneven in respect to the use of specialists to enrich training programs. Many agencies reported no involvement of other than the director of the service in their training programs.

Specialists most frequently reported as assisting in training were:

Home economists—337 agencies
Nurses—320 agencies
Nutritionists—307 agencies
Physicians—222 agencies
Social workers—214 agencies
Psychiatrists—180 agencies
Physical therapists—158 agencies
Occupational therapists—124 agencies

A variety of other specialists were used, particularly safety experts. Four hundred fifty-one agencies indicated that their training programs were carried out under the overall direction of one person, usually the director of the homemaker service program.

While the data are incomplete and should be used only as indicators, they do show that most agencies were providing some training and trying to relate it to the content of the homemaker's job.

Records

Responses to questions relating to gathering, maintaining and using statistical data about clients and the services provided for them, indicated that this is largely a neglected area of practice. A few agencies were unable to provide data about the number of persons served during the study month; some could give a case count but could not give information about the number of children in the family, or a count of families in which the parent was out of the home. Some agencies which served adults could not indicate how many lived alone. Some agencies could only give a case count and total hours of service, with no detail as to types of families. A few kept no record of hours of service at all. Many agencies maintained no count of requests for service which they were unable to meet.

Seventy-three agencies even reported maintaining no count of persons currently receiving services; 153 reported that they did not maintain a count of requests received; 190 reported maintaining no data about the nature of the problem for which service was requested, while 183 reported maintaining no count of the total actually accepted for service. Only 402 reported that they maintained a count of pending cases. Even less information was available about denied applications. While 340 reported that they maintained a count of referrals received for service, some apparently did not take any responsibility for referring those they were unable to serve to another source of help.

Responses to the questions indicated that many agencies do not provide for the gathering and maintenance of readily retrievable data to support program planning, financing, interpreting, and accounting for service.

In view of the responses, it was not surprising to learn that only 312 reported that they maintained a cost accounting system of any sort. Most public welfare and half of the voluntary family and children's agencies generally did not use any cost accounting methods for homemaker service. Presumably, this service was "integrated" with other services and costs were not identified separately.

The implications of these findings are serious indeed. If the many questions from the field and from the general public, as well as program questions for individual agencies, are to be dealt with constructively, better methods of gathering, maintaining and using data are urgently needed.

Financing

There had been a marked shift in the financing of homemaker service from voluntary support to public support since 1961. This was reflected in the growth of public agencies and in the dependence of voluntary agencies on public funds for part of their financial support (Tables 8 and 9). Whereas in 1961 there were 66 public and 142 voluntary agencies, in 1966 the proportion of public to voluntary agencies was more than four to three. Moreover, only 293 agencies, public and voluntary, reported using any voluntary funds, eight of which were public agencies. Only 73 reported all support from voluntary sources. Thus, it would appear that 607 of the agencies were partially dependent on public support and 387 looked to public funds entirely. While the survey asked respondents to indicate the major sources of support, few gave this information. While figures reported here relate to number of agencies, not to relative amounts of money involved, it is safe to say that greater amounts of public than voluntary funds were involved. (See Table 8.) The largest single group of agencies, employing the most full-time homemakers, were public welfare agencies. Of all voluntary agencies, family and children's agencies employed the most full-time homemakers and only 55 of them reported relying upon voluntary funds entirely. Only six independent agencies and 13 voluntary health agencies reported depending entirely upon voluntary funds.

Homemaker services, public and voluntary, seek financial support from a variety of resources. Except for public welfare, few agencies reported relying wholly on any one source.

Public welfare agencies most consistently depended upon public welfare funds, but a few utilized other resources, such as OEO, contracts and third party payments, community and other voluntary funds.

Fees for service were reported by 362 agencies, 102 of which were public. No agency reported relying totally on fees for financial support, and few indicated that it was a significant source of funding. All but five independent agencies provided some service on a fee basis; all but 22 voluntary health agencies and more than half of the voluntary family and children's agencies did so.

Contracts and third party payments were reported as a source of support for most health agencies, public and voluntary. Independent community agencies also reported this as a source. However, only one agency reported this as its only source of support. A few agencies reported payment for homemaker service by health insurance programs, a relatively new but growing development.

In examining the variey of voluntary funds which support homemaker service (Table 9), community funds stood out as the major voluntary resource. Endowments, sponsoring organizations, funds raised by the agency board, foundation support and a variety of gifts and other resources were reported by some agencies as helping to finance their programs.

Among the public resources for financing homemaker services, public welfare funds were the most significant, with contracts and third party payments, and public health funds next in order. OEO funds were reported by 53 agencies. It was the intent of the survey to determine the extent to which various Federal funds (child welfare service, public assistance, maternal and child health and "formula grants" from the U.S. Public Health Service) and state and local tax funds were used. This was not possible, however, because many local agencies were unable to distinguish among these sources of funds. It would appear, also, that eight voluntary agencies erroneously reported using Federal public assistance funds from direct appropriations to support their homemaker service programs.

In summary, it can be said that homemaker service has followed the pattern of development which has been characteristic of many other service programs. It developed first under voluntary auspices. As the need was demonstrated and the demand for a larger volume of service grew, agencies turned to public (tax) funds for financing. Often there has been an intermingling of public and voluntary funds at the local level. The growth of Medicare, Medicaid, maternal and child health programs, and the various "poverty" programs resulted in a variety of resources for third party payments for service, on a case by case basis. The unsolved question for most communities is how to harness these many financial resources, each with its own legislative base and set of regulations, to meet the broad range of needs for service.

Where public funds are available on a contract or fee-for-service basis, can the community develop a broad-based service which will meet the volume of need for all groups, provide for continuity of care, and also meet the special needs of some groups? This is the challenge if each community is not to be forced into specialized services—for children, for the aged, for the sick, etc.—which meet some needs but create categories into which many persons do not fit neatly, resulting in gaps, duplication, and confusion. Sources of financing seem to be the key factor. Is the community agency with access to both voluntary and public funds *the* answer? Will two or more kinds of agencies be needed in all of the larger communities? What is the optimum or maximum size of an effective homemaker service agency? When and for whom should agencies serving specialized groups be established? These are some of the pressing questions to which the field needs to address itself if adequate and effective arrangements for financing are to be forthcoming.

Salaries and Wages

Variations in response to questions relating to salaries and wages showed that some agencies employed homemakers both on a salary and on an hourly wage; some reported only salaried employees and others employed homemakers only on an hourly wage. Two hundred and twenty-nine public agencies reported that homemakers received a salary, while only 116 voluntary agencies reported salaries. On the other hand, 219 voluntary agencies reported homemakers receiving hourly wages as against 146 public agencies.

Examination of individual questionnaires suggested that public child welfare agencies tended to employ more homemakers on hourly wages than did other types of public welfare agencies. Most public welfare agencies reported employment of homemakers on the basis of both salary and hourly wage. While 365 agencies reported that they employed some or all of their homemakers on an hourly basis, only 88 guaranteed a minimum weekly wage, regardless of the hours worked, and only 67 guaranteed a minimum number of hours of work.

The following table shows the breakdown of responses by type of agency:

Type of Agency	Number Paying Salaries	Number Paying Hourly Wages
Public	229	146
Welfare	187	97
Health	35	42
Health and welfare	0	3
Other	7	4

Voluntary	116	219
Family or children's	73	97
Visiting nurse	22	43
Home health care	8	16
Independent homemaker	9	61
Other	4	2
Total	345	365

The range in salaries was great—from less than $100 to more than $500 per month, with the majority of agencies reporting between $250 and $400 per month. Wage scales showed a similar range. (See Tables 10 and 11.)

In addition to wage scales, the survey inquired about related practices—such as payment for overtime, payment while in training status, payment for travel costs, and employee benefits. Some agencies reported that no overtime was required; of those whose homemakers worked more than the regular work week (35-40 hours), compensatory time was more frequently allowed than payment for overtime. A total of 64 public and 124 voluntary agencies reported that they paid for overtime; most public and 145 voluntary agencies provided compensatory time off. Some agencies apparently did both, paying for hours worked when the homemaker was paid an hourly wage, with time off for salaried homemakers. However, wages or salaries did not always appear to be the significant factor in determining whether time off was allowed or overtime paid. Public agencies tended to pay newly employed homemakers while undergoing initial training, while only about two-thirds of the voluntary agencies did so. Full salary or wage while in training was paid by 170 public agencies; 25 paid part; 150 voluntary agencies paid full wage or salary, 49 paid part.

On-the-job travel costs were paid by 238 public agencies and 125 voluntary agencies. It would appear that far too many agencies expected homemakers to meet all costs attributable to work out of their own pay. It would be interesting to examine practice in respect to other employees in these agencies—e.g., caseworkers, nurses and other staff whose jobs require travel from one family to another—to see if they were treated in the same way.

Little information was obtained about salaries paid to directors of homemaker service programs. However, examination of individual questionnaires provided some information. The range of reported salaries for directors was from $4,000 in one small, voluntary homemaker service program in New England and in one public welfare program in Mississippi, to $12,900 per annum in some of the larger public and voluntary agencies. Many agencies reported a salary of $8,000 to $10,000 per year.

Employee Benefits and Protection

The survey requested data about practice in respect to employee benefits—Social Security coverage and voluntary retirement plans, paid vacations, workmen's compensation, group health insurance, periodic pay increments, and liability insurance coverage. Apparently, most agencies responded appropriately to most of these questions.

Neither Social Security nor voluntary retirement coverage for homemakers was reported by eight public health, three combined public health and welfare agencies, four VNAs, 29 family or children's agencies, 22 independent community agencies, and eight of the "other" voluntary agencies. It is safe to assume that this did not accurately reflect practice in at least some of these agencies, since Social Security coverage would be required by all employing agencies, except possibly certain public agencies.

The failure of many agencies to provide workmen's compensation for their homemakers was striking, particularly in light of the risks of injury and/or illness involved in their jobs. This suggests the need to review standards of agency operation and to encourage agencies to provide these minimum benefits. Hourly workers were a particularly neglected group.

Paid vacations for homemakers were not uniform practice by any means and generally were provided only for homemakers on a salary. Only 30 agencies gave paid vacations to hourly workers. Paid vacations were provided by 213 of the 371 public agencies, 166 in welfare and 33 in health programs. Only 97 of the 309 voluntary agencies reported providing paid vacations. Periodic pay increments were reported by 193 public agencies and 128 voluntary agencies.

Agencies providing personal care for ill and disabled persons and for the frail aged were asked if they provided liability insurance for their homemakers. While 540 reported that they provided personal care, only 256 agencies reported that they provided liability insurance for their homemakers—120 of these were public and 136 were voluntary agencies. Twenty-four public agencies and 66 voluntary agencies, reported that they carried malpractice insurance.

One can only conclude that families, homemakers, and agencies are not generally protected adequately against the hazards entailed in providing and using homemaker services.

Uniforms

Practice in respect to homemakers wearing uniforms on the job varied. Three hundred and fifty agencies required that their homemakers wear uniforms. Most health agencies (133), public and voluntary, required uniforms, as did 66 independent community agencies. Only 69 public welfare and about one-half of the family and children's agencies reported that they required uniforms.

The method of payment (i.e., whether on salary or paid by the hour) did not seem to be an important factor in respect to requiring uniforms. A more significant finding was that many agencies requiring uniforms did not furnish them. While health agencies were most likely to require uniforms, they frequently did not furnish any; 19 public health agencies furnished the first uniform only, four furnished all; 27 voluntary health agencies furnished the original uniform and only 17 furnished all uniforms.

On the other hand, of the 69 public welfare agencies requiring that their homemakers wear uniforms, 17 furnished the first uniform only and 40 furnished all uniforms; of the 69 voluntary family and children's agencies requiring uniforms, 35 provided all and 23 provided the first uniform only. Although 66 independent agencies reported that they required their homemakers to wear them, only 15 furnished the first uniform and only seven furnished all uniforms.

These figures take on added significance in view of salary and wage scales below the "poverty level" in more than half the agencies.

Summary

In summary, there is no "typical" homemaker service agency or program in the United States today. There are many patterns, with a variety of auspices sponsoring the service. Perhaps it is fair to say that programs which are a part of a larger agency, such as public welfare, public health, visiting nurse association, or a voluntary family or children's agency, tend to follow patterns of structure and service already developed in the "parent" agency. Thus they reflect the great variety and pluralistic approach to service which is characteristic of this nation.

It is difficult to get an accurate profile of the independent homemaker service agency. There appears to be great variation in respect to size of program, location, sources of financing, length of initial training for homemakers, in-service training, professional background of directors and supervisors, use of consultation, wage scales and employee benefits.

On the other hand, in a few areas, the independent agencies were generally consistent. Sixty-eight of the 73 reported that they served both families with children and adults, and that preserving the home and family life is a basic purpose. Nearly all reported having training programs with content related to the services homemakers provide. They generally employed homemakers on a part-time basis, paying an hourly wage (only nine reported employment on salary). Nearly all reported keeping statistical data on services and maintaining a cost accounting system. While 61 reported that they provided personal care, only 17 reported liability insurance coverage and only five reported malpractice insurance. Most required uniforms, but few provided them, even the initial one. As a group, they provided minimum employee benefits generally with few guaranteeing any basic wage, regardless of hours worked, or a minimum number of hours of employment.

Attempts to develop a "profile" of each type of agency proved to be futile, because of the great variation in each group, whether health or welfare, public or voluntary. It would appear that homemaker service is fluid in its present stage of development without a consistent pattern. It was not the purpose of this survey to examine the extent to which agencies meet the minimum standards established by the National Council for Homemaker Services. However, the findings suggest the need for more uniform standards and practices.

This is a clear challenge to the field for the immediate future.

Introduction to Tables

Each table is presented so as to stand on its own. The reader is cautioned to keep in mind that not all tables will "add up," because of several factors: (1) not all questions were mutually exclusive; (2) not all agencies responded to all questions; (3) a few responses were so unclear as to necessitate their elimination from the tabulations.

Finally, Puerto Rico reported its 79 local welfare programs as one statewide program, which has resulted in under-reporting the number of public welfare programs (actually 357 instead of 279) and the overall number of homemaker service programs (768 instead of 680). However, the report deals with the Puerto Rico Department of Public Welfare as one agency in order to provide data comparable to those obtained in the 1961 and 1963 reports.

Table 1. Agencies providing homemaker services and number of families served, by type of agency: October 1961, 1963, and 1966

	Number of agencies				Number of families served[1]			
Type of Agency	1966	1963	1961	Net change 1963-1966	1966	1963	1961	Net change 1963-1966
Total	680[2]	303	208	377	23,864	9,547	5,454	14,317
Public	371[2]	112	66	259	11,510	3,020	1,899	8,490
Welfare	279[2]	93	66	186	8,611	2,835	1,899	5,776
Health	78	15	0	63	1,400	172	0	1,228
Other	14	4	0	10	1,499	13	0	1,486
Voluntary	309	185	142	124	12,354	6,270	3,555	6,084
Family or children's	142	116	101	26	3,621	2,837	2,037	784
Visiting nurse	57	21	8	36	3,253	844	269	2,409
Health[3]	....	12	6	....	....	1,122	198	....
Independent homemaker	73	32	20	41	4,453	1,338	769	3,115
Home health care[3] [4]	23	....	....	....	876	....	....	....
Other	14	4	7	10	151	129	282	22
Combined[3]	....	6	....	....	....	257	....	....

[1] Includes adults living alone.

[2] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

[3] Comparable data not available.

[4] Includes all voluntary agencies, other than Visiting Nurse Associations operating under such health auspices as voluntary hospitals and health associations.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 2. **Agencies providing homemaker services, by type of family unit served and type of agency: October 1966**

Type of Agency	Number of agencies	Only families with children	Adult families only[1]	Both types of families	No response
Total	680[2]	191	53	413	23
Public	371[2]	166	31	158	16
Welfare	279[2]	156	2	109	12
Health	78	7	29	33	4
Health and welfare	3	0	0	3	0
Other	11	3	0	8	0
Voluntary	309	25	22	255	7
Family or children's	142	21	4	115	2
Visiting nurse	57	2	13	42	0
Home health care	23	1	4	18	0
Independent homemaker	73	0	1	68	4
Other	14	1	0	12	1

[1] Includes adults living alone or with spouse, relative, or friends.

[2] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 3. Families and children served and number of hours of service, by type of family unit and type of agency: October 1966

Type of Agency	Number of agencies in survey	Families with children: parent in home		Families with children: no parent in home		Adults living with spouse, relative or friend	Adults living alone	Hours of Service		
		Families served	Children served	Families served	Children served			Total	Families with children	Adults only
Total	680[1]	9,494	28,848	874	3,484	7,541	5,955	423,267	234,925	188,342
Public	371[1]	6,281	17,434	495	2,208	2,237	2,497	181,320	126,192	55,128
Welfare	279[1]	5,162	15,682	361	1,825	1,270	1,818	155,305	117,516	37,789
Health	78	218	697	53	186	711	418	20,713	4,936	15,777
Health and welfare	3	66	220	9	0	8	10	1,583	1,420	163
Other	11	835	835	72	197	248	251	3,719	2,320	1,399
Voluntary	309	3,213	11,414	379	1,276	5,304	3,458	241,947	108,733	133,214
Family or children's	142	1,988	7,829	130	497	703	800	111,831	74,247	37,584
Visiting nurse	57	259	793	83	116	2,071	840	37,518	7,564	29,954
Home health care	23	66	195	13	67	594	203	15,714	1,387	14,327
Independent homemaker	73	856	2,429	149	583	1,864	1,584	72,578	22,965	49,613
Other	14	44	168	4	13	72	31	4,306	2,570	1,736

[1] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 4. Educational attainment and major fields of study of directors of homemaker services, by type of agency: October 1966

Type of Agency	Educational level						Major fields of study				
	Number of agencies in survey	High School	College, no degree earned	Bachelor's degree	Master's or doctoral degree	Other	Social Work	Nursing	Home Economics	Education	Other[1]
Total	680[2]	44	105	288	231	255	355	163	127	247	163
Public	371[2]	21	41	186	115	136	201	59	69	145	80
Welfare	279[2]	8	21	159	85	94	176	8	46	119	56
Health	78	12	19	21	24	38	19	51	15	19	23
Health and welfare	3	0	0	1	2	1	1	0	2	2	0
Other	11	1	1	5	4	3	5	0	6	5	1
Voluntary	309	23	64	102	116	119	154	104	58	102	83
Family or children's	142	3	19	47	71	41	104	9	29	49	38
Visiting nurse	57	7	12	20	17	21	11	49	13	19	11
Home health care	23	4	8	7	4	11	8	18	3	2	6
Independent homemaker	73	8	21	24	20	38	30	19	12	30	26
Other	14	1	4	4	4	8	1	9	1	2	2

[1] Includes such other fields as business, psychology, and economics.

[2] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 5. **Types of staff responsible for overall, continuing plan for an individual or family receiving homemaker services, by type of agency: October 1966**

Type of Agency	Number of agencies in survey	Social caseworker	Nurse	Other
Total	680[1]	420	184	154
Public	371[1]	276	74	62
Welfare	279[1]	267	6	35
Health	78	3	67	17
Health and welfare	3	2	0	2
Other	11	4	1	8
Voluntary	309	144	110	92
Family or children's	142	119	8	34
Visiting nurse	57	1	55	5
Home health care	23	2	20	4
Independent homemaker	73	19	18	46
Other	14	3	9	3

[1] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 6. Number of full and part-time homemakers and homemaker supervisors employed, by type of agency: October 1966

Type of Agency	Number of agencies in survey	Number of homemakers			Number of supervisors		
		Total[1]	Full-Time	Part-Time	Total[1]	Full-Time	Part-Time
Total	680[2]	7,965	4,114	3,613	1,041	584	483
Public	371[2]	2,716	1,877	638	535	289	269
Welfare	279[2]	2,159	1,641	317	386	204	198
Health	78	402	116	287	117	62	62
Health and welfare	3	42	25	17	4	2	2
Other	11	113	95	17	28	21	7
Voluntary	309	5,249	2,237	2,975	506	295	214
Family or children's	142	1,827	1,137	691	208	110	98
Visiting nurse	57	899	420	479	104	58	51
Home health care	23	212	93	119	32	17	15
Independent homemaker	73	2,267	568	1,661	145	99	44
Other	14	44	19	25	17	11	6

[1] Differences between total columns and the respective component colums are attributable to incomplete data from same agencies.

[2] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 7. Agencies with training programs for homemakers and length of initial training period, by type of agency: October 1966

	Number of agencies			Length of initial training period			
Type of Agency	Total	With organized training programs	With initial training	20 hours or less	21-40 hours	41-80 hours	over 80 hours
Total	680[1]	519	537	205	174	82	66
Public	371[1]	255	277	89	87	51	44
Welfare	279[1]	174	191	67	61	40	21
Health	78	68	72	18	24	10	16
Health and welfare	3	2	3	1	0	1	1
Other	11	11	11	3	2	0	6
Voluntary	309	264	260	116	87	31	22
Family or children's	142	106	103	67	27	7	3
Visiting nurse	57	55	55	22	19	8	5
Home health care	23	21	22	3	10	4	2
Independent homemaker	73	70	67	21	30	11	4
Other	14	12	13	3	1	1	8

[1] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 8. **Sources of agency financial support for homemaker services, by type of agency: October 1966**

Type of Agency	Number of agencies in survey	Voluntary Support			Public Support				Contracts and third party payments	Fees for service
		Total	All[1]	Partial only	Welfare[2]	Health[2]	OEO[3]	Other		
Total	680[4]	293	73	220	309	131	53	40	281	362
Public	371[4]	8	1	7	285	58	25	18	71	102
Welfare	279[4]	2	0	2	273	3	11	9	6	44
Health	78	5	1	4	9	55	4	5	64	57
Health and welfare	3	0	0	0	1	0	2	1	1	0
Other	11	1	0	1	2	0	8	3	0	1
Voluntary	309	285	72	213	38	70	28	22	210	260
Family or children's	142	137	55	82	11	10	15	4	66	128
Visiting nurse	57	52	7	45	8	26	4	6	55	50
Home health care	23	16	0	16	2	9	3	1	20	18
Independent homemaker	73	68	6	62	16	23	6	8	61	62
Other	14	12	4	8	1	2	0	3	8	2

[1] Includes agencies which accept fees for service.
[2] Does not include contracts or third party payments.
[3] Office of Economic Opportunity; community action projects only.
[4] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 9. Sources of voluntary financial support for homemaker services, by type of agency: October 1966

	Number of agencies in survey	Number with voluntary support	Community fund	Endowment	Sponsoring organization	Funds raised by agency board	Foundation funds	Other voluntary contributions
Total	680[1]	293	223	41	79	71	65	98
Public	371[1]	8	4	3	3	1	2	4
Welfare	279[1]	2	2	1	2	1	1	1
Health	78	5	2	2	1	0	0	3
Health and welfare	3	0	0	0	0	0	0	0
Other	11	1	0	0	0	0	1	0
Voluntary	309	285	219	38	76	70	63	94
Family or children's	142	137	117	27	26	24	25	38
Visiting nurse	57	52	47	8	4	6	6	10
Home health care	23	16	8	0	7	5	3	7
Independent homemaker	73	68	41	3	31	26	29	37
Other	14	12	4	0	8	9	0	2

[1] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 10. Agencies employing homemakers on hourly basis, by average of minimum and maximum wage paid and by type of agency: October 1966

Type of Agency	Number employing on hourly basis[1]	Average of hourly wage range					
		Less than $1.25	$1.26-1.50	$1.51-1.75	$1.76-2.00	$2.01-2.25	$2.26-2.50
Total	365	122	141	70	26	5	1
Public	146	76	31	23	13	3	0
Welfare	97	59	17	15	5	1	0
Health	42	15	14	7	5	1	0
Health and welfare	3	1	0	1	1	0	0
Other	4	1	0	0	2	1	0
Voluntary	219	46	110	47	13	2	1
Family or children's	97	31	40	20	6	0	0
Visiting nurse	43	3	23	11	4	1	1
Home health care	16	4	10	0	2	0	0
Independent homemaker	61	8	36	15	1	1	0
Other	2	0	1	1	0	0	0

[1] Includes some agencies that also reported employment of homemakers on a salary basis.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 11. Agencies employing homemakers on a salary basis, by average of minimum and maximum monthly salaries paid and type of agency: October 1966

Type of Agency	Number employing on salary basis[1]	Average of monthly salary range[2]									
		Less than $100	$100-150	$151-200	$201-250	$251-300	$301-350	$351-400	$401-450	$451-500	More than $500
Total	345	9	8	23	85	107	76	24	6	4	3
Public	229	9	6	12	48	69	54	21	6	2	2
Welfare	187	8	4	11	37	58	43	16	6	2	2
Health	35	1	2	1	10	7	10	4	0	0	0
Health and welfare	0	0	0	0	0	0	0	0	0	0	0
Other	7	0	0	0	1	4	1	1	0	0	0
Voluntary	116	0	2	11	37	38	22	3	0	2	1
Family or children's	73	0	0	8	26	23	13	1	0	1	1
Visiting nurse	22	0	1	1	6	8	4	1	0	1	0
Home health care	8	0	0	1	3	2	1	1	0	0	0
Independent homemaker	9	0	1	1	1	3	3	0	0	0	0
Other	4	0	0	0	1	2	1	0	0	0	0

[1] Includes some agencies that also reported employment of homemakers on an hourly basis.

[2] Based on minimum and maximum monthly full-time salaries paid before deductions.

Prepared by: Community Profile Data Center, DMCA, U.S. Public Health Service.

Table 12. Distribution, by Region and State, of agencies with homemaker services, number of families served, and number of homemakers employed: October 1966

Region and State	Number of agencies			No. of families served		Number of homemakers employed		
	Total	Public	Voluntary	Families w/children	Adults only	Total[1]	Full-time	Part-time
TOTAL	680[2]	371	309	10,368	13,496	7,965	4,114	3,613
REGION I								
Connecticut	26	2	24	333	407	386	87	297
Maine	4		4	8	13	19	2	17
Massachusetts	25	2	23	284	467	413	127	286
New Hampshire	1		1	3	6	8		8
Rhode Island	12	7	5	71	123	63	24	29
Vermont								
REGION II								
Delaware	1		1	9	2	7	5	2
New Jersey	23		23	331	826	914	181	689
New York	70	28	42	1,269	1,452	1,322	1,018	304
Pennsylvania	32	5	27	496	1,197	533	224	309
REGION III								
Dist. of Col.	1		1	94	71	76	17	59
Kentucky	34	33	1	244	6	75	43	32
Maryland	7	3	4	92	66	107	83	24
North Carolina	43	39	4	1,271	548	129	119	10
Puerto Rico	2[2]	2		286	213	453	414	39
Virginia	6	1	5	102	65	43	37	6
Virgin Islands								
West Virginia	2		2	9	58	24	7	17
REGION IV								
Alabama	2	1	1	1	68	12	1	11
Florida	7	1	6	57	569	255	31	224
Georgia	8	6	2	456	648	65	57	8
Mississippi	14	14		51	16	28	26	2
South Carolina	1	1		10	12	5	5	
Tennessee	5	4	1	133	22	28	23	5

REGION V								
Illinois	23	9	14	546	235	409	155	72
Indiana	21	9	12	118	417	127	83	44
Michigan	25	11	14	355	695	217	139	78
Ohio	49	25	24	482	972	371	297	74
Wisconsin	46	38	8	931	308	114	73	41
REGION VI								
Iowa	12	5	7	80	325	219	17	202
Kansas	2		2	4	2	5	5	
Minnesota	39	30	9	391	321	245	99	146
Missouri	12	5	7	243	262	91	89	2
Nebraska	1		1	30	80	13	9	4
North Dakota	4	3	1		23	8		8
South Dakota	6	5	1	10	1	7	4	3
REGION VII								
Arkansas	6	5	1	18	5	17	17	
Louisiana	7	5	2	24	8	41	37	4
New Mexico	2	2		33	142	55	11	44
Oklahoma	1		1	3		3	2	1
Texas	15	11	4	167	259	131	100	31
REGION VIII								
Colorado	13	11	2	283	235	76	62	14
Idaho								
Montana	13	13		46	19	28	13	15
Utah	1		1	8	61	10	7	3
Wyoming	6	6		20	34	12	4	8
REGION IX								
Alaska	1	1		13		4	1	3
Arizona	5	2	3	86	222	29	26	3
California	27	13	14	636	1,792	628	267	361
Guam								
Hawaii	1	1		6		3	3	
Nevada	2		2	12		51	13	38
Oregon	6	5	1	68	147	41	28	13
Washington	8	7	1	145	14	45	22	23

[1] Detail does not add to total because several agencies did not report number of full-time and part-time homemakers.

[2] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.

Table 13. Distribution by Region and State, of public and voluntary agencies providing homemaker services: October 1966

Region and State	Public agencies					Voluntary agencies					
	Total	Welfare	Health	Health and welfare	Other	Total	Family or children's	Visiting nurse assoc.	Home health care	Independent homemakers	Other
TOTAL	371[1]	279[1]	78	3	11	309	142	57	23	73	14
REGION I											
Connecticut	2	2				24	10	3		11	
Maine						4	2			1	1
Massachusetts	2	2				23	11	3	1	5	3
New Hampshire						1	1				
Rhode Island	7	7				5	5				
Vermont											
REGION II											
Delaware						1	1				
New Jersey						23	3		1	19	
New York	28	20	5	1	2	42	24	7		10	1
Pennsylvania	5	4	1			27	11	4	2	9	1
REGION III											
Dist. of Col.						1				1	
Kentucky	33	32			1	1	1				
Maryland	3	2	1			4	2	1		1	
North Carolina	39	38	1			4	1				3
Puerto Rico	2[1]	1[1]	1								
Virginia	1	1				5	3	1	1		
Virgin Islands											
West Virginia						2	2				
REGION IV											
Alabama	1		1			1		1			
Florida	1	1				6	2	1		3	
Georgia	6	3	2		1	2		1	1		
Mississippi	14	13	1								
South Carolina	1	1									
Tennessee	4	4				1	1				

REGION V											
Illinois	9	8	1			14	9	2	2		1
Indiana	9	4	4		1	12	5	7			
Michigan	11	1	7		3	14	5	6	2	1	
Ohio	25	8	17			24	11	4	7		2
Wisconsin	38	35	3			8	5	3			
REGION VI											
Iowa	5	1	3		1	7	1	2	2	2	
Kansas						2	2				
Minnesota	30	20	9		1	9	6	2	1		
Missouri	5	4	1			7	6		1		
Nebraska						1		1			
North Dakota	3		3			1			1		
South Dakota	5	5				1	1				
REGION VII											
Arkansas	5	5				1	1				
Louisiana	5	3	2			2	2				
New Mexico	2	1	1								
Oklahoma						1	1				
Texas	11	7	2	2		4	2	1		1	
REGION VIII											
Colorado	11	10	1			2		1		1	
Idaho											
Montana	13	13									
Utah						1		1			
Wyoming	6	3	3								
REGION IX											
Alaska	1	1									
Arizona	2	2				3	1			2	
California	13	9	4			14	2	5	1	4	2
Guam											
Hawaii	1	1									
Nevada						2				2	
Oregon	5	1	4			1	1				
Washington	7	6			1	1	1				

[1] Data for 79 public welfare agencies in Puerto Rico were reported as one Statewide program; thus the number of agencies is under-reported by 78.